Four Seasons (DFK) Limited

Hilltop Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on the 25 October 2018. At the last inspection carried out on the 18 January 2018, 19 January 2018 and 9 February 2018 we found three breaches in Regulations. The provider breached Regulations because they had not ensured that people were safeguarded from potential harm, people's risks were not mitigated to keep them safe, medicines were not managed safely and the service lacked monitoring systems to enable poor care to be identified and mitigated.

Following the last inspection, we served a Notice of proposal to request monthly updates from the provider to show the actions in place to make improvements to the care people received and to meet the Regulations. The provider voluntary agreed to restrict any further admissions into the service until they had made the required improvements. At this inspection, we found that some improvements had been made. However, there were two continued breaches in regulations and a new breach in regulation was identified. The provider agreed to continue to voluntarily restrict admissions into the home until the required improvements were made.

Hilltop Manor Care Home 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.

Hilltop Manor Care Home accommodates up to 80 people in one adapted building. At the time of the inspection there were 32 people using the service. The provider had made the decision to support people on the ground floor due to the low occupancy at the home.

There was a newly appointed manager at the service who was in the process of applying to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a lack of oversight at the service and the management team had been inconsistent. Systems in place to monitor the service and mitigate risk to people were not consistently effective in identifying and rectifying concerns with the way people's care was provided. This meant people had continued to receive a poor standard of care.

Medicines were not managed safely. People's risks were not always mitigated which placed them at potential risk of harm.

People did not always receive a good experience at meal times and improvements were needed to ensure people were supported in a timely and dignified way.

People were not always supported in a caring, dignified and respectful way. Staff did not always promote and encourage people's choices in the way they wanted their care providing.

We have made a recommendation about the environment for people living with dementia.

Improvements were needed to ensure all incidents were reported to ensure people were safeguarded from potential harm.

Improvements were needed to ensure staff were deployed effectively. Systems in place to learn when things went wrong were not always effective in identifying and improving the care people received.

Training provided had not always been effective which impacted on the care people received.

People's diverse needs were not consistently assessed and planned to ensure their diverse needs formed part of the support received.

People were protected from the risks of infection and people were supported by safely recruited staff.

People were supported in line with the Mental Capacity Act 2005, which ensured people were supported in their best interests and in the least restrictive way possible.

People had access to healthcare professionals and staff received a handover to ensure they were aware of a change in people's needs.

Staff felt the manager was supportive and approachable. The manager had started to implement regular supervisions to ensure staff had the opportunity to discuss their role.

People were supported in privacy and to maintain relationships that were important to them.

People and relatives were involved in the planning and review of care to ensure this was provided in line with their preferences. People had the opportunity to be involved in activities within the service.

People and their relatives knew who to make a complaint to if needed and there was a system in place to investigate and monitor complaints

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People were supported to have a comfortable and pain free death.

The newly appointed manager had made some improvements to the systems in place to monitor the service. However, these still needed to be fully implemented and imbedded into the service.

People and relatives felt that the manager was approachable and feedback was gained about the care provided.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

Medicines were not consistently managed to keep people safe from harm. People's risks were not always mitigated which placed them at potential risk of harm.

Improvements were needed to ensure all incidents were reported to enable investigations to be completed and safeguarding referrals to be made where needed. Improvements were needed to ensure staff were deployed effectively. Systems in place to learn when things went wrong were not always effective in identifying and improving the care people received.

People were protected from the risks of infection and people were supported by safely recruited staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not always receive a good experience at meal times and improvements were needed to ensure people were supported in a timely and dignified way.

Training provided had not always been effective and improvements were needed to ensure staff understood and used the training provided when supporting people.

We have made a recommendation about the environment for people living with dementia.

People were supported in line with the Mental Capacity Act 2005, which ensured people were supported in their best interests and in the least restrictive way possible. People were supported to access healthcare professionals and staff received a handover to ensure they were aware of a change in people's needs. The manager had started to implement improvements to ensure staff felt supported in their role.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported in a caring, dignified and respectful way. Staff did not always promote and encourage people's choices in the way they wanted their care providing.

People were supported in privacy and were supported to maintain relationships.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were needed to ensure people's diverse needs were consistently assessed and planned to ensure their care was provided in line with their preferences.

People and relatives were involved in the planning and review of care to ensure this was provided in line with their preferences. People enjoyed the activities on offer.

People and their relatives knew who to make a complaint to if needed and there was a system in place to investigate and monitor complaints.

People were supported at the end of their life to ensure they were comfortable and pain free at this stage of their life.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of oversight at the service and the management team had been inconsistent, which meant that areas of poor practice and poor culture had not been identified in a swift manner. This meant people had continued to receive a poor standard of care.

Systems in place to monitor the service and mitigate risk to people were not consistently effective in identifying and rectifying concerns with the way people's care was provided.

The newly appointed manager had made some improvements to the systems in place to monitor the service. However, these still needed to be fully implemented and imbedded into the service.

People and relatives felt that the manager was approachable and were asked for feedback about the care provided.

Hilltop Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 inspection took place on 25 October 2018 and was unannounced. The inspection team, consisted of three inspectors and a medicines inspector.

Before the inspection we reviewed information, we held about the service. This included notifications that we had received from the provider about events that had happened at the service, which the provider was required to send us by law. For example, serious injuries and safeguarding concerns. We also contacted commissioners of the service to gain their experiences. The service had been placed under a Large Scale Enquiry (LSE) by the Local Authority. An LSE is held when the local authority have concerns about a service and professionals are invited to discuss the actions to be taken. We received regular updates at the LSE with regards to the progress the provider was making to improve the quality of care to people. We also received monthly action plan updates from the provider to show how they were making improvements at the service.

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 spoke with four people and three relatives to gain their experiences of the service. We spoke with a registered nurse, four members of care staff, the manager and the regional manager. We observed care and support in communal areas. We viewed six records about people's care and treatment. We also viewed ten people's medication records and observed how medication was managed and administered to people. We looked at how the service was managed which included four records for staff employed at the service and audits to monitor the quality of the care provided.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found that people's risks were not consistently mitigated and medicines were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements were still needed and there was a continued breach in Regulation.

Administration records for the topical treatments that were applied by the care staff were not able to demonstrate that they were being applied in accordance with the prescriber's instructions. For example, we looked at a topical MAR chart for a moisturising gel, which stated the gel was to be applied twice a day. The topical MAR chart showed that since the 17 October 2018 the gel had only been applied on four occasions. If the topical MAR chart was demonstrating this gel had been applied as prescribed we would have seen the topical MAR chart signed on 17 occasions. Staff we spoke with were unable to verify whether people had received their creams as prescribed. Therefore we could not be assured that people were supported to have their topical creams administered in line with the prescribers guidelines.

People could not be assured that their medicines would be managed safely. We reviewed how controlled drugs were managed in the home. Controlled Drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found the Controlled Drugs were stored correctly and their administration was being recorded in a Controlled Drugs register where an accurate running balance of the Controlled Drugs was being maintained. However, we found one person had not had their analgesic patch changed at the correct interval on three occasions. The patches in question should be changed every seven days, however on one of these occasions the patch was not changed until after ten days had elapsed which may have resulted in this person experiencing increased symptoms.

We looked at the patch application records for people who were having the analgesic skin patches applied to their bodies. We found that the provider was making a good record of where the patches were being applied however, this record showed that the patches were not always being applied in line with the manufacturer's guidance. This meant the patches were not being applied safely and could result in people experiencing unnecessary side effects.

Some people who had been prescribed medicines on a when required basis had records that had insufficient information to inform the staff of how and when to administer these medicines. For example, several when required protocols for the administration of Paracetamol informed staff that the reason for administration was "To relieve symptoms of general aches, observe [person's name] body language, facial expressions and verbal communication" but did not specify what the staff should be looking for when looking for an individual who was in pain. Consequently, we witnessed a person who was in pain was not being treated effectively. We looked at one person who had been prescribed a medicine to relieve agitation and we found there was no information for staff to follow on when the medicine was required. Over a 17-day period the administration records showed that this medicine had been administered on eight occasions. We looked at the daily notes to see what behaviours were warranting the administration of this medicine and found no information to suggest the administration of this medicine was required.

We also found where people needed to have their medicines administered directly into their stomach through a tube the provider had not ensured that the necessary information was in place to ensure that these medicines were prepared and administered safely. We spoke with the nurse on duty about how the medicines were being prepared and found if the medicines were tablets the tablets were being crushed and suspended in water before pushing through the tube and into the stomach. We noted that one of the tablets being crushed was Finasteride, which is used for the treatment and control of benign prostatic hyperplasia. Women who are pregnant or may become pregnant are warned not to handle broken or crushed Finasteride tablets. This is because if Finasteride is absorbed through the skin or taken by mouth by a woman pregnant with a male foetus, the child may be born with malformed genital organs. The concern here was the provider had not carried out a risk assessment to determine whether any members of its staff were being put at risk by carrying out this procedure.

People's risks were not consistently managed to protect people from potential harm. For example; one person had a specialist mattress in place and they had been assessed as requiring this to be set on 4.5. The records we checked contained gaps in recording and we found that the mattress had regularly been set on 4. On the day of the inspection this person's mattress was set at 5. This meant that the person was at risk of inappropriate support for their skin integrity. There were gaps in recording for three other people who needed their mattress set at a certain level, which meant we were unable to assess whether their mattresses were consistently at the correct settings. These people did not have current pressure areas. However, this meant that people were at risk of a deterioration in their skin because staff had not always ensured people's mattresses were at the correct settings to maintain their skin integrity.

We viewed one person's care records which stated they had been assessed by the Speech and Language Team (SALT) for advice with regards to their swallowing. The SALT had assessed this person as requiring a straw to drink fluids. The care plan for this person had been updated to include the information for staff to follow. However, during the inspection we saw that this person was not given a straw and had been provided with a lipped beaker for their drinks. This meant that this person was at risk of choking because staff were not supporting them with their risks in line with the SALT guidance.

The above evidence demonstrated that people's assessed risks and prescribed medicines were not consistently managed in a safe way. This was a continued breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that people were not consistently protected from harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made to meet the regulation. However, some further improvements were still needed.

People and their relatives told us that they felt they were safe when staff supported them. One person said, "I feel safe here because I know there are day and night staff and the building is secure". One relative said, "We have never had any issues with my relative's safety. We feel they are safe here". Staff we spoke with told us they would report concerns immediately to the registered manager. The records we viewed showed that the registered manager had reported alleged abuse to the local safeguarding authority. However, after the inspection we were informed by the Local Authority that there were some instances where incidents had not always been raised by staff as a concern, such as unexplained bruising. This meant that the registered manager had not carried out an investigation and had been unable to consider whether a safeguarding referral was required. We met with the provider who informed us that they had taken steps to ensure that all potential safeguarding concerns were reported and investigated as required.

People and relatives we spoke with gave mixed experiences of the staffing levels within the service. One person said, "I have had to wait for a long time before breakfast and sometimes I am waiting a long time to go to the toilet. The staff seem disorganised". Another person said, "The staff do come when I press my buzzer, although it can take a while sometimes". A relative said, "There always seems enough staff when we are here, I don't have any issues with the staffing levels". There was a lack of oversight with regards to the deployment of staff within the service, which meant that people had some poor experiences. For example; we observed mealtimes were disorganised, which meant that people had to wait for their meals and people who were assisted to eat were left in the middle of their meal to enable staff to support other people. Staff we spoke with felt there were enough staff on duty but they did not always have enough time to chat with people. One staff member said, "There is enough staff, but it would be good if we could spend some time chatting with people as some people do not have any family and we are all they have". The manager and regional manager told us they were still looking at the deployment of staff across the service and they had plans to spend more time in communal areas to gain an insight of the issues we had raised with regards to the deployment of staff. This meant that improvements were needed to ensure staff were deployed across the service effectively.

The provider had not always learnt when things went wrong at the service. Some improvements had been made at the service. For example; people's risk of falls had been mitigated to ensure that people were safe. The manager had ensured that people's weights were monitored and action taken to lower people's risk of malnutrition. However, some of the areas that needed improvements had had not been acted on to make improvements to people's care. Improvements were needed to ensure effective systems were in place for the manager and provider to pro-actively recognise when things went wrong. This would ensure learning from these issues were taken before they had been highlighted by other professionals such as; inspectors from the Care Quality Commission and the local authority. This meant that improvements were needed to ensure that there were systems in place to ensure lessons were learnt when things went wrong to improve the quality of the service.

Staff had been employed using safe recruitment procedures. Staff told us and we saw that they had received checks of their character and references from previous employers. Checks had been carried out with the Disclosure and Barring Service (DBS). DBS carries out criminal record checks to ensure staff are suitable to work with vulnerable people. This meant people were supported by staff that were of suitable character and had been recruited safely.

People and relatives told us that the service was always clean. We saw that the environment and equipment were clean and there was a cleaning schedule in place. We saw domestic staff cleaning all areas of the service throughout inspection. We observed staff wearing gloves and aprons when they supported people and staff told us that these were always available for them to use. The manager explained how they ensured that staff prevented the risk of cross contamination. This meant people were protected from the risk of infection and cross contamination.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that improvements were needed to ensure staff had sufficient knowledge of the Mental Capacity Act 2005 (MCA)to enable them to support people effectively. Improvements were needed to the support people received with their meals and improvements to the environment to meet people's diverse needs. This area was rated as requires improvement. At this inspection we found that improvements had been made to ensure staff understood their responsibilities in line with the MCA. However, we found further improvements were still needed. This area continued to be rated as requires improvement.

People received a poor experience at lunch because staff did not treat people with respect and dignity when assisting people to eat. For example; we observed a staff member assisting a person to eat. The staff member was not giving this person their dedicated time and was talking across other people to a staff member, whilst they were assisting this person to eat. The manager entered the room and was in the dining room whilst this staff behaviour continued. However, they did not identify that this was poor practice and disrespectful to people. The manager told us that they had not heard or seen this behaviour. We saw staff assisting another person to eat their meal and they left this person on two occasions in the middle of their meal without any explanation. This person had to wait to finish their meal until a second member of staff arrived to assist them with their meal. This practice was undignified and meant that some people received a poor experience.

We observed one person had been provided their meal and they had fallen asleep and had not touched their food. Staff had not recognised that this person had not been encouraged with their meal and they were left asleep in front of their meal. We informed the manager that this person had not been supported with their meal when they entered the dining room. The manager woke this person and asked them if they wanted their lunch. There had been a period of 45 minutes that this person's food was on the table and there was no consideration as to whether this food would be cold and fit to eat. We saw another person had been sat with their food in front of them for a period of 50 minutes before they received support from staff to eat their meal. Staff did not give consideration as to whether this meal would still be fit to eat. This demonstrated there was a culture that did not always promote a caring experience for people when receiving support from staff.

The showed that people were not treated in a dignified and respectful manner. This was a breach of Regulation 10 of the Health and Social Care Activities 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received an induction when they were employed at the service. This included training to help them provide care effectively. Staff told us that they had received regular updates in training and felt the training had helped them to understand how to support people effectively. However, we saw that the training staff had received had not always been effective. For example; staff had received dignity in care training after concerns were raised at our previous inspection. At this inspection we saw people were not always treated with dignity and respect, which meant the training received had not made the necessary improvements to the way people received their care. We fed back our findings to the manager and regional

manager who were unaware of the practices we had observed. During a provider meeting on 8 November 2018, the manager and regional manager told us that they planned to implement further dignity in care training. They stated that staffs' understanding would be assessed by completing regular observations of staff interactions with people. We will assess the effectiveness of these plans at our next inspection. This meant that improvements were needed to ensure staff had the knowledge and understanding to consistently support people in a dignified way.

People's needs were met by the adaptation and decoration of the service. We saw that the corridors of the service aided people's mobility as they were large and spacious with no trip hazards, which meant people's risk of falling was lowered. Adapted facilities were available which included bathrooms with equipment to ensure people were supported safely when bathing. There was information available to people in a pictorial form to help them understand what was the date, weather and the menus for the days meals. However, further improvements were needed to ensure the environment was suitable for people living with dementia to aid orientation around the service. For example; people's names were on doors but these were small and would not always aid people's understanding when identifying their bedrooms. The corridors to people's rooms and toilets did not contain adequate signage to aid people's orientation around the service. Menus were available to people but these were not in pictorial form, which would help people to understand what meals were on offer.

We recommend that you use current guidance available to make improvements to the environment for people living with dementia.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Some people were unable to understand some decisions about their care and we checked that the provider was meeting their responsibilities under the Mental Capacity Act 2005. We saw mental capacity assessments had been carried out when people lacked capacity, which contained details of how staff needed to support people to make specific decisions in their best interests. Staff we spoke with understood their responsibilities under the MCA and what it meant for people they supported. This meant the provider acted in accordance with principles of the MCA where people lacked the capacity to make informed decisions.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. Staff were aware of the restrictions in place and we saw staff supported people to keep them safe from harm in line with their individual DoLS. This meant that people were supported in the least restrictive way and in line with the MCA.

People had access to healthcare services. One person said, "I am supported to visit the hospital as I have painful legs". A relative said, "My relative was having difficulty eating and they referred them for an assessment. They eat better now and their weight has been maintained". Staff told us about the specific health needs of people and the documentation we saw evidenced that referrals to healthcare professionals had been made. For example, one person had received a visit from a podiatrist to ensure their foot care was maintained. Another person had received a visit from a district nurse to apply and remove dressings to their legs. Where people had fallen we saw that referrals for occupational health therapist support was made and

specialist equipment to lower people's risk of falls was provided. This showed us that staff worked in partnership with other organisations to ensure people were supported to maintain their health and wellbeing.

Improvements had been made to the way people's nutritional risks were mitigated. We saw that people who were at risk of malnutrition and/or dehydration were monitored regularly. People's weights were monitored and where people's weight had decreased this monitoring was increased and referrals made to ensure people were protected from further weight loss. Food and fluid charts were in place to ensure that people were eating and drinking sufficient amounts throughout the day. These charts were monitored during the daily walk round by the manager who ensured staff were aware of people who needed extra encouragement to maintain their food and drink levels. This meant that people were supported to maintain healthy nutrition and hydration levels.

Staff received a handover at the change of each shift to ensure that the support people received was consistent and staff were aware of a change in people's needs. The handover record contained details of appointments with health professionals and any changes in people's needs that staff needed to be aware of. The handover also contained details of people's wellbeing during each shift to ensure staff were aware of any specific support people needed. This showed us that there was a system in place to ensure staff were informed of changes in people's needs.

Staff told us that the manager was approachable and they felt that improvements had been made since the appointment of the new manager. One staff member said, "I can see a difference already, the paperwork is a lot better and easier to understand. [Registered manager's name] is approachable and listens". A staff meeting had been held and the manager had started to carry out supervisions. One member of staff said, "I have received a supervision now and I am sure they will become more regular with the new manager". The registered manager showed us a plan of supervisions to be held and we saw a group supervision had been held with staff to discuss improvements needed when recording in people's daily records. This showed that improvements were in the process of being made to ensure staff felt supported in their role.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found improvements were needed to ensure people received a consistently caring service. At this inspection there continued to be concerns because people were not consistently supported in a caring and dignified way. We found a breach in regulation and this area continued to be rated as requires improvement.

People were not consistently supported in a caring and respectful way. For example; staff did not always interact with people in a caring way. For example, we observed one person being hoisted from their wheelchair into a lounge chair. Staff did not explain how they were going to support this person and only stated "going up" and "going down". The person appeared distressed throughout the transfer and the care records we looked at stated that this person was anxious when they were being supported to move. However, the staff we observed did not provide any comfort to allay this person's anxieties whilst they were being moved. This demonstrated a lack of care and respect for this person's anxieties. We observed people were sitting alone in the conservatory after the activities had finished. A member of staff entered the conservatory and looked around and completed a record to state they had checked that people were okay. However, there was no caring interaction with people to ask if they were okay and if they needed anything. We also observed three members of staff providing drinks to people in the conservatory. The staff did not interact with people whilst they were making the drinks and we saw the three staff members talking between themselves discussing people who used the service. We saw people were looking at the staff members but were not spoken with until the staff gave people their drinks. This demonstrated a lack of care and respect for people who used the service.

People's choices and wishes were not always respected to make them feel cared for. For example; we observed a member of staff asked one person if they wanted their food cut up. However, the staff member did not wait for a response but continued to cut this person's food before they had made a choice. We saw another staff member wipe a person's nose. However, there was no interaction with this person to ask if they wanted this support. During the morning drink we saw people were not given a choice of drink and there was no engagement or positive interaction from staff to people. There was no caring encouragement or explanation to make this person feel looked after.

Staff did not consistently treat people with dignity. For example; we observed one person becoming anxious in the dining room. We heard staff in the kitchen state, "[person's name] is having a turn". We also observed a staff member assisting this person to eat and they said, "You are in one of those moods today, aren't you?" This demonstrated that staff were not respectful and used undignified language about the person they were supporting.

The above evidence demonstrated that people were not consistently supported in a caring, dignified and respectful way. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we observed some concerns with the way people were cared for, we received some positive

feedback from people who used the service. One person said, "They [staff] are very helpful, they look after me well". Another person said, "The staff consider my dignity when they help me in the shower". Relatives told us that they had seen caring interventions between staff and their relatives. For example; one relative told us that staff respected their relative's wishes and the staff were caring when they supported them. Another relative told us they had seen the staff visit them in their room ad have a quick chat and they like to 'banter' with the staff. People told us that staff ensured they were supported with personal care in their bedrooms or bathrooms to ensure their privacy was protected. We saw some interactions between people and staff that were caring. For example; we saw two people ask for a blanket because they felt cold, the staff member immediately went and fetched a blanket and asked if the two people were okay and felt better for the blanket. We saw the activity co-ordinator interacted well with people during the exercises and provided encouragement in a positive caring manner.

People told us their relatives visited them and they could access their bedrooms so that they were able to have privacy with their visitors. Relatives told us that they visited their relatives at any time throughout the day and staff were always welcoming. We saw one relative visit at lunchtime and staff asked them if they wanted a drink whilst they visited their relative. This meant people were supported to maintain relationships that were important to them.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found improvements were needed to ensure people's diverse needs were assessed and people were involved in their care. This area was rated as requires improvement. At this inspection we found that improvements were still needed and this area continued to be rated as requires improvement.

We found that people's diverse needs were not fully assessed before they started to use the service and this important information was not always available to staff. For example; people's cultural and religious preferences had not always been considered to ensure that this part of their life was maintained. We also found that other diverse needs such as sexuality had not been considered at the assessment stage and people's sexual orientation were not detailed in the care records. We fed this back to the management team at the close of the inspection and we were informed that they would ensure this important information was gained to make sure people's diverse needs were assessed and plans put in place to ensure these needs were considered where needed. This meant that there was a risk that people were not receiving a fully personalised service because all aspects of their life had not always been considered.

People and relatives told us and care records showed that they were involved in the assessment and planning of their care. One person said, "I am involved in my care. The staff ask if I need anything changing or things doing differently. I am able to make these decisions about my care". A relative said, "We were involved in my relative's care planning when they first came to the service and we are invited to reviews. This is an opportunity for us to raise any issues and ensure my relative is getting the care they need". One person told us how they preferred a shower in the afternoon and liked to go to bed after watching a specific television programme. They told us that staff respected their wishes and the records we viewed conformed that these preferences had been recorded. Staff we spoke with had a good understanding of people's preferences and the way people like their care providing. The care plans we viewed contained people's preferences in how they wished their care to be provided and details of who people wished to be involved in the planning of their care. We saw that reviews had been completed and people were involved in this process. This showed that people were involved in their care planning which was provided in line with their preferences.

People told us that there were activities on offer such as; exercising to music, arts and crafts, gardening and people's birthdays were celebrated. One person said, "I like some of the activities on offer such as the bingo and singing. I do like to garden in the summer which staff help me to do". A relative said, "My relative enjoys the activities and likes to be involved". There was an activity co-ordinator at the service who planned activities and supported people with various activities. This member of staff was responsible for providing mental stimulation for people in communal lounges and in bedrooms. During the inspection we saw the activity staff member leading 'movement to Music' with people, which was light exercise carried out in the lounges. This member of staff encouraged people to be involved and where people chose not to be involved in certain activities this was respected. People responded to time spent with the activity staff member by smiling and laughing in a relaxed manner. This demonstrated that people had the opportunity to be involved in activities within the service.

People and their relatives told us they knew how to complain. One person said, "I would speak with the manager if I needed too. I'm not afraid to speak up". A relative said, "I have raised a concern with the manager in the past and it was dealt with straight away. It wasn't a formal complaint just a niggle". The provider had a complaints policy in place and we saw that there was a system in place to log any complaints by the registered manager. We found that there had not been any complaints recorded at the service at the time of the inspection. We were unable to assess whether this system was effective in responding to people's complaints.

We found that people's end of life wishes had been gained to ensure they were involved in the way they were cared for at this stage of their lives. This included information about people who were important to them, specific clothes they would like to wear and the arrangements they had in place after their death. One person was being supported at the end of their life and we saw a specific care plan was in place, which showed discussions around medicines which was reviewed twice a month to ensure the person's pain was managed. The care plan also contained details of the person's preferences in how they wished to be cared for. This meant people were supported to be comfortable and pain free at the end of their life.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we found that the systems and processes in place had not been operated effectively to ensure people received a consistently good and safe standard of care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements were still needed and there was a continued breach in Regulation.

The provider continued to ineffective oversight of the service and there had been issues with regards to the sustainability of the management which had led to a lack of action taken with regards to the implementation of the systems to monitor the service. For example; the provider had appointed a new manager, regional manager and managing director with the last two months before our inspection. There was also a resident experience team who assessed the experiences of people who received a service. The new manager showed us the systems they had implemented at the service since they were appointed. This included audit trackers, staff supervisions, skin integrity audit, weight audits and food and fluid audits. We saw these had been effective in making some improvements. However, the issues we identified at the service had not been recognised and action had not been taken to make improvements to the way people received their care.

The service has been in LSE with the local authority for over 12 months however, due to the instability of the leadership team and changes in management they have been unable to implement sustainable improvements in the quality and safety of care that people received. Our inspection highlighted that the systems implemented by the provider to lever change and improvements have not been applied consistently and they have not been effective at addressing all of the shortfalls that we identified during our previous inspection. The regional manager and managing director have provided a commitment to the commission that they will provide focussed resources to support the new manager in addressing the shortfalls that we identified during our inspection. However, the instability in leadership and management over the last 12 months and lack of effective monitoring by the provider has meant that people's experience of living in the home and receiving care has been negatively compromised.

After the last inspection we imposed a condition on the provider's registration. This condition stated that the provider was required to forward a monthly action plan to show the improvements made at the service. We viewed the action plan received from the service before our inspection which was dated 19 October 2018. This showed that some actions had been completed such as skin charts, safeguarding training and supervisions. However, we found that some of the actions that showed as complete had not been effective. For example; the action plan stated that staff have received a thematic supervision around dignity, but we found this had not been effective in ensuring people were consistently treated with dignity and respect. The action plan also stated that bed mattress checks were completed daily by staff and the settings were reviewed monthly. However, we found that there were gaps in these checks and people's mattresses were not consistently set at the assessed settings. We found there was not a system in place to ensure that staff were completing these checks correctly. The regional manager told us that the improvements still need to be imbedded and sustained at the service due to the recent changes in the leadership. This meant that people were still at risk of inconsistent care because the improvements made had not always been effective

and were not imbedded into the service.

There was a culture within the service which had impacted on the way people were treated. People had experience poor care because of this negative culture within the staff group. Effective systems to consider, monitor and improve people's experience of living in the home and receiving care had not been implemented. We viewed trackers for a daily walkabout which was completed by the manager, senior carer or nurse. These trackers had not identified the issues we saw at the inspection. We feedback our concerns to the manager and the regional manager who agreed that staff needed further training to ensure they were treating people in a caring and dignified way. This demonstrated that the systems in place to ensure staff treated people in a kind, caring and respectful manner were not effective.

We asked the resident experience staff member how they ensured people received positive caring interactions when being supported by staff. We saw records of observations that had been carried out. However, these observations had not identified the concerns we noted during our inspection; specifically, people's mealtime experience in the home despite observations of this having been made by staff. We viewed records of an observation of the dining experience carried out on 5 September 2018 by the resident experience staff member. The records identified that cutlery and condiments were not always available. However, these audits did not show observations of interactions between people and staff or whether people were assisted in a timely way. We viewed dining experience trackers that were tick sheets completed by the nurse and senior staff. These showed that staff had observed people being supported with meals in a timely and dignified manner. There had been no issues identified in each of the monthly trackers completed. However, these were not carried out by the management team and there was a risk that the staff completing the observations had not recognised the poor culture within the home as they worked within this culture. This meant that the system in place to ensure people received a positive dining experience were not effective in identifying poor practice

Medicines were not managed safely and the system in place to monitor medicines had not been effective in identifying areas of concern. For example; we found concerns with the management of topical medicines, people's pain relief patches were not always administered as prescribed and PRN protocols contained insufficient guidance for staff to follow. We viewed a medication tracker that had been completed on 23 October 18. This was a tick sheet which had not identified concerns with medicines management. This meant the system in place was ineffective because the concerns we identified had not been identified by the audit and rectified.

The above demonstrated that effective governance systems were not in place to monitor the service and mitigate risks to people, which led to people receiving a poor standard of care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The newly appointed manager had implemented some systems at the service which ensured people's skin, weight and nutritional wellbeing was monitored. We saw this had ensured improvements were made in these areas and people's risks were lowered. Action had also been taken to address the concerns regarding the monitoring and mitigation of people's risk of falling. We saw that the improvements had ensured care records were updated and staff were aware of the support people needed to lower their risk of falls. These systems were newly implemented and we were unable to assess the sustainability of these new systems. These will be assessed at our next inspection.

People and relatives were positive about the manager and stated that they were approachable. One person said, "I know who the manager is and I would talk to them if I needed to". A relative said, "Things have started to improve, definitely recently since the new manager has arrived". Relatives told us they had been

invited and attended meetings at the service. They told us that discussions took place about the planned improvements and if relatives had any concerns they wanted to raise at the meeting. One relative said, "The last meeting was about eight weeks ago with the new manager, I am always invited and it is a good opportunity to raise any issues". We saw that feedback had been gained from people and their relatives during weekly visits by the resident experience team. The feedback we viewed was positive. This meant the manager was approachable and people were given the opportunity to feedback on their experiences.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently supported in a caring, dignified and respectful way.

The enforcement action we took:

We served a warning notice to ensure improvements were made and the regulation was met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's assessed risks and prescribed medicines were not consistently managed in a safe way.

The enforcement action we took:

We served a warning notice to ensure improvements were made and the regulation was met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective governance systems were not in place to monitor the service and mitigate risks to people, which led to people receiving a poor standard of care.

The enforcement action we took:

We served a warning notice to ensure improvements were made and the regulation was met.