Romney Cottage Residential Care Home

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Inspection report

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Date of inspection visit: 25 and 26 January 2016
Date of publication: 07/03/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We undertook an unannounced inspection of this service on 25 and 26 January 2016. Romney Cottage Residential Care Home is registered to provide accommodation and support for up to 22 older people. There were 16 people living at the service. People at the service are older people living with dementia, some of whom have limited mobility. Accommodation is provided over two floors with communal lounges and dining areas. Most people had their own bedroom, although some were shared. Access to the first floor is gained by a stairs, making some areas of the service inaccessible to people with limited mobility.

Our previous inspection on 2 October 2014 found breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

We asked the provider to take action in relation to the governance of the service, aspects of staff training and to ensure that Deprivation of Liberty Safeguards (DoLS) were in place for people unable to consent to care and treatment at the service. The provider gave us an action plan and told us the work needed to meet these requirements would be complete by the end of April 2015. The registered manager further informed us August 2015 all shortfalls identified were addressed.

At this inspection we found the provider had not met all elements of each requirement action. As a result, we found the service continued to breach regulations relating to fundamental standards of care. In addition, other serious failings placed people at risk.

Risk assessments did not reflect people's changing needs and reviews of incidents and accidents did not result in action for staff to take to try to prevent people being at risk again. People suffered repeated falls.

People were risk of not receiving appropriate care and support because guidance about how people should be supported was not always in place where needed.

Unmonitored temperatures meant that medicines may become desensitised and ineffective, administration of medicine was not always recorded and management of medicines did not meet with published best practice.

People received poor care because there were not enough staff on duty, this meant people were left unsupervised and caused a delay in the administration of one person's medicine.

People were at risk of scalding because excessively high water temperatures were not addressed. The service was not adequately maintained, identified works had not taken place and damp or water ingress affected on person's bedroom.

Induction training had not been signed off as complete or evaluated; staff operated equipment that they were not trained to use. Staff did not have the necessary skills to support some people.

Mental capacity assessments had not been completed to determine if some people could consent to care and treatment at the service or before restrictions on their liberty was imposed. This did not meet the requirements of the Mental Capacity Act.

Assessments had not been completed to determine if people needed adapted utensils to help them eat and none were provided. Some peoples did not receive appropriate support to eat when they were unable to eat independently.

Staff did not have sufficient knowledge or benefit from best practice procedures to identify early signs that may indicate deterioration in a person's condition. This meant people did not always benefit from the opportunity of early intervention or, if needed, medical referrals.

Care plans did not always reflect the involvement of people. This meant care provided may not meet their preferences or some needs; in some instances care planning did not establish individual needs and preferences, for example, in relation to continence care.

Most people felt the activities were too limited and would only take place if staff had time. People's hobbies and interests had not been explored and activities particularly beneficial to people with dementia were not practiced.

Leadership at the service had not ensured that all requirement actions issued following our last inspection were met. The service lacked an effective oversight, quality assurance framework and management action plan for ongoing improvement and development.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection

Summary of findings

will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Risk assessments did not always record suitable measures required to keep people safe or respond to their changing needs.

Incidents and accidents did not receive suitable oversight or promote learning to reduce the risk of them happening again.

Recruitment records were incomplete and insufficient staff impacted on the supervision of other people and delayed the administration of medication. Medicines were not suitably stored, managed or recorded.

The service was not appropriately maintained, planned work had not taken place and dangerously hot water temperatures were not addressed.

Is the service effective?

Inadequate

The service was not effective.

Training had not been evaluated and staff used equipment they had not been trained to use. Staff did not have the necessary knowledge and skills to support some people effectively.

People did not have mental capacity assessments in place that were decision specific or showed the steps taken to support them to make decisions themselves. This did not meet with the principles of the Mental Capacity Act 2005.

People were not supported to eat and assessment or provision of adapted cutlery or plates had not taken place.

Practices did not provide effective recognition of early signs of deterioration in people or meaningfully support for people at risk of dehydration or malnutrition.

Is the service caring?

Requires improvement

The service was not always caring.

Staff were dedicated and compassionate, however, task orientated interactions did not always promote the best care outcomes for people.

Care planning did not reflect the involvement of the people the plans were intended to support.

People spoke positively of the care they received and felt they were treated with dignity and respect. Staff adopted an inclusive, kind and caring approach.

Visitors told us they were made to feel welcome when they visited the service.

Summary of findings

Is the service responsive?
The service was not always responsive.

Activities were limited and did not meet most people's expectations.

Aspects of care plans were not sufficiently developed to provide meaningful guidance for staff about how some people needed to be supported.

A complaints procedure in place and people felt comfortable raising any concerns or making a complaint.

People's religious and cultural needs were accommodated.

Requires improvement

Is the service well-led?
The service was not well led.

Action had not been taken to fully address breaches of regulations identified during the last inspection.

Checks and audits had not identified shortfalls found during this inspection or enabled the provider to meet regulatory requirements.

The service lacked a management plan to ensure continuous improvement and development.

Inadequate

Romney Cottage Residential 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 in response to concerns raised with us, and to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced inspection of this service on 25 and 26 January 2016. The inspection was undertaken by two adult social care inspectors.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for and interacted with staff. We looked in detail at care plans and examined records which related to the running of the service. We looked at six care plans and five staff files as well as staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed such as audits, policies and risk assessments. We also pathway tracked some people living at the home. This is when we look at care documentation in depth and obtain people's views on their day to day lives at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked around most areas of the home including some bedrooms, bathrooms, the lounge and dining areas as well as the kitchen and laundry area. During our inspection we spoke with nine people who live at the home, one visitor, two visiting health care professionals, three care staff, the home's cook and the registered manager.

We reviewed the information we held about the service. We considered information which had been shared with us by the local authority and healthcare professionals such as a clinical nurse specialist. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. Comments included, “I know all the staff by name, they know about the help I need" and "I’m happy with the support I need and feel safe and looked after”. Another person told us, “I don’t have any concerns, we get along well”.

Our last inspection on 2 October 2014 found the service was not always safe and identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was about a lack of systems and governance within the service to ensure checks of cleanliness and infection control were monitored. We asked the provider to take action to make sure people were safe and not unnecessarily exposed to the risk of infection. During this inspection we found that the provider had taken steps to improve and infection control measures. However, the requirement action had not been fully met because we identified other areas of concern, not addressed by governance processes, which meant that the service was not safe.

People were at risk of unsafe care and treatment because risk assessments did not always record sufficient measures required to keep people safe. For example, a risk assessment identified one person may fall from their chair and noted that staff should encourage the person to move to alternative seating. During the inspection, each member of staff identified the risk of the person falling from their chair; however, none of the staff were able to successfully encourage the person to move to a different chair. Therefore, the risk of falling had not been reduced and, inevitably, the person tipped their chair over causing them to fall to the floor. Sufficient consideration was not given to alternative strategies, such as the provision of a more suitable chair or continuous supervision by staff and therefore, the risk of falling was not suitably mitigated.

Risk assessments were inconsistent, they did not always reflect people’s changing needs and measures in place intended to reduce risk were not always followed. For example, one person sustained 12 falls in a six month period. Although a GP referral was made and medication reviewed, the person fell six more times in a five week period following the GP referral. No further GP referral was made following these falls. The risk assessment had not been updated; however, their mobility assessment indicated when deemed necessary a wheel chair should be used to aid safe mobility. Records of the most recent incident showed the person fell when walking across the lounge. Measures intended to safely support the person’s mobility were not embedded into practice. Additionally, there was no indication that preventative measures suggested by the GP, such as the service testing for urinary tract infections, which can cause unsteadiness and disorientation, had taken place.

People were at risk of continuing injury and poor care because investigation of accidents and incidents did not reflect learning to minimise the risk to people of incidents happening again. Management of accidents and incidents did not feedback into risk assessment reviews. There was no system of oversight or analysis of incidents and accidents which may have identified trends and allowed for timely interventions.

Medicine management was not safe. We assessed the procedures for the ordering, receipt, storage, administration, recording and disposal of medicines. The temperature of the medication storage trolley was not monitored to ensure maximum temperatures (25 c) were not exceeded. This presented a risk that medicine stored at an incorrect temperature may become desensitised and potentially ineffective. Medicine administration records (MAR) were not always completed by staff when prescribed medicines were administered. The MAR is a part of a person’s care records, staff are required to sign the record at the time that the medicine is administered or code the MAR correspondingly if medicines are not given or are refused. The failure to do so presents a risk that medicine has not been administered and that medicine may be incorrectly re-administered by another staff member. Some prescriptions on MAR charts had been updated and written by hand; the new entries were not always dated to know when they came into effect or double signed as an indication of a double check to make sure the new information was correct. Where people were prescribed creams for their skin, there was, in some cases, no guidance for staff about when, where or how these should be applied. This placed people at risk of inconsistent treatment and care. Where medicines were given to people when needed (PRN), there was often no guidance in place to support this and records were incomplete. For example, in the case of variable amounts, the amount of medicine given was not always recorded. Recording of how much was administered would help to make sure that too much was not taken within unsuitable timeframes. Medicine

administration records did not include a photograph of the person and there was no explanation of what the medicines were for. This did not promote the safe administration of medicines.

The provider had failed to ensure risk assessments recorded sufficient measures to keep people safe; that they were appropriately reviewed; reflective of people's changing needs and did all that was reasonably possible to mitigate risks. People were at risk associated with the unsafe use and management of medicines. This was a breach of Regulation 12 (1)(2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of receiving poor care which impacted on their safety because there were not enough staff on duty. The registered manager told us that staffing levels were determined according to the dependency levels of people; however, no specific staffing tool was used and dependency assessments in care plans were incomplete or blank. There were 16 people living at the service at the time of our inspection. Day shifts ran from 7am to 7pm and consisted of three staff, including the registered manager, with an additional carer providing four hours of care each morning. At the weekends two care staff supported people in the mornings and three care staff in the afternoon. Night cover, from 7pm to 7am, was provided by two care staff, one waking and one sleeping. Seven people needed the support of staff for all of their personal care and three more people needed help with aspects of their personal care. There was no deputy manager in place and only one senior carer. When not at the service, the registered manager provided on call support. Agency staff had been increasingly used; the registered manager told us there were three unfilled care staff vacancies. Cooking, housekeeping and maintenance duties were provided by ancillary staff.

Staff told us work felt hectic at times, particularly if people were unwell or needed one to one support for any period of time. During our inspection, each of the care staff identified the risk of a person falling from their chair, but due to his drowsiness, were not successfully able to encourage him to move to an alternative chair. The person was left unsupervised, their chair tipped over and they fell to the floor. All three staff on duty were occupied for 45 minutes dealing with this incident. During this time, no staff were available to support or supervise the remaining 15 people. Additionally, this incident caused a 35 minute delay in the monitoring of blood sugar levels and administration of insulin for a person with diabetes.

The service had not ensured there were, at all times, sufficient numbers of staff to meet the needs of the people. This was in breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to ensure that the premises and any equipment used are safe. Checks of fire prevention and detection equipment were arbitrary. For example, sample testing of smoke alarms meant some had not been checked for two years. Schedules indicated automatic door closing devices should be checked weekly, however, staff were unable to confirm this had taken place. Some annual fire extinguisher checks last occurred 15 January 2015 and had therefore fallen overdue. Hot water temperature checks, intended to safeguard against the risk of scalding, took place monthly. Although we were told thermostatic mixer valves (TMV) were in place, hot water temperatures to the wash hand basins in each person's bedroom, the communal bath and shower exceeded the maximum permitted safe temperature set out in the service's hot water and surfaces policy. Although excessively hot water temperatures were recorded, no action had been taken to address this risk, despite warnings within the policy that such temperatures 'can be very serious and have led to fatalities'.

Areas of the service had been treated and re-plastered where damp had been coming into the property. A recent plaster repair in an occupied bedroom was wet where damp or water ingress remained an issue. Most areas of repaired plaster throughout the home were bare and not redecorated. A schedule of maintenance planned for the redecoration of particular bedrooms, the first floor toilet as well as the bathroom, treatment room and laundry all situated on the ground floor to be completed by the end of 2015. Discussion with the registered manager and our observation around the service found this work had not been completed. Repair, redecoration and refurbishment had not kept pace with the rate of wear. An accumulation of old furniture, beds and chairs dumped in the courtyard, did not provide a pleasant aspect for people using and visiting the service and could represent an additional fire risk.

Inadequate

Is the service safe?

The provider had not ensured safety critical fire detection and prevention equipment was appropriately tested; dangerous water temperatures were not rectified; maintenance was not adequately planned, prioritised or carried out. This was in breach of Regulation 15 (1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected as far as practicably possible by a safe recruitment system. Records did not always show gaps in employment histories were checked. Although Disclosure and Barring Service (DBS) checks were undertaken when staff were recruited, records were not always kept when the results were received, therefore it was not possible determine if staff began working at the service before DBS checks were received. Similarly, one member of staff had commenced work at the service before their references of previous employment were received. Systems in place were incomplete; this did not promote the principles of a robust recruitment process to protect the safety of people living at the service.

This is a breach Regulation 19 (1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records confirmed the service had cooperated with the local authority when safeguarding concerns were identified. Systems were being established to address issues, previously featuring in safeguarding investigations to help staff spot signs of people deteriorating, which could lead to earlier interventions, for example, loss of weight linking to underlying conditions. Discussion with staff showed that they understood about keeping people safe from harm and protecting them from abuse. Staff realised that acts of neglect also constituted abuse. Most staff had received training in safeguarding adults. They were able to describe different types of abuse and knew the procedures in place to report any suspicions of abuse or allegations. There were up to date safeguarding and whistle blowing policies, which staff knew how to locate. Staff were familiar with the process to follow if any abuse was suspected; they had access to Kent and Medway safeguarding protocols and knew how to contact Kent County Council safeguarding team to report or discuss any concerns.

Inadequate

Is the service effective?

Our findings

People were positive about the quality of care provided. People told us they had confidence in the staff who supported them, they felt staff understood their needs and knew how to meet them. Comments included, “They look after me well”, “The staff are hardworking” and “All of the staff seem very capable”.

Our last inspection on 2 October 2014 found the service was not always effective and identified breaches of Regulations 18 and 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were about ineffective induction training for new staff and a failure to follow the Mental Capacity Act (MCA) when restrictions were placed upon people to help keep them safe. We asked the provider to take action to make sure induction training suitably prepared staff for their roles and to ensure that any restrictions placed upon people met with the MCA and Deprivation of Liberty Safeguards (DoLS). During this inspection we found the provider had taken steps to improve but had not fully met these previous shortfalls. We also identified other areas of concern which meant that the service was not effective.

In their action plan, the registered manager gave an undertaking that ‘new staff would be required to complete the new care certificate and supervised until complete over a 12 week duration’; and ‘anyone having previously worked in care settings would still be required to complete the care certificate, but not necessarily supervised for the full 12 week duration’. The Care Certificate is a set of standards that social care workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

Training records showed although staff, including the three newest care staff, had started the training towards the care certificate, no course work for any staff had been evaluated by the registered manager or senior carer. Additionally, no competency checks, other than medication administration, had taken place to ensure any training provided was embedded into practice. Staff rotas showed a number of occasions when two staff, recently the subject of induction training, were the only staff providing night support at the service. Neither of these staff had completed protection of vulnerable adults, challenging behaviour in dementia or infection control training. Since induction training had not been evaluated or signed off as completed, the service could not demonstrate staff had acquired suitable skills and knowledge either during induction or through ongoing training.

During the inspection staff needed to use a hoist to lift a person who had fallen to the floor. None of the staff, including the registered manager and senior carer, were accredited moving and handling trainers or had completed training in how to use the hoist. Staff initially tried to use the hoist without fully closing the valve used to let the hoist arm down, this meant it was not initially possible to lift the person from the floor; every time staff tried to raise the hoisting arm, it returned its rested position. This was disconcerting for the person being supported because it did not instil confidence in the staff around him and extended the time he spent on the floor.

Staff had not received appropriate training to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

DoLS form part of the Mental Capacity Act (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place are intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS should ensure that the least restrictive methods are used.

The MCA requires providers to submit DoLS applications to a ‘Supervisory Body’ for authority to impose restrictions. Applications had been made to the local authority for 11 people who were unable to leave the service without continuous supervision. Decisions about these applications were still pending. Most of the staff, including the registered manager and senior carer had received training about MCA and DoLS. However, mental capacity assessments had not taken place to establish if people had capacity to consent to restrictions, such as supervision outside of the service, before DoLS applications were made. This did not meet with the principles of the MCA. This was because one of the basic principles of the MCA is that people should be presumed to have capacity unless appropriate assessment determines they have not.

Inadequate

Is the service effective?

Assessments of people's mental capacity should be about specific decisions; record the steps taken to reach a decision; or any measures taken to help people form their own decisions.

People's rights to make unwise decisions (decisions that may place them at risk) were not always respected or received appropriate support. For example, several people smoked. While a smoking area was provided, staff controlled the supply of three people's cigarettes. There was no record that people had agreed to these restrictions, that their capacity to make such a decision was considered or evidence of 'best interests' meetings. If a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests. This is one of the principles of the MCA. The measures in place at the home did not meet the principle of the MCA because a person's agreement or lack of capacity to make such an agreement had not been established.

The absence of mental capacity assessments where restrictions were imposed did not show an embedded understanding or practices which met the principles of the MCA 2005. This is a breach of Regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were mainly positive about the food provided at the service, comments included, "The food is good, we can make suggestions about what we want and we get it" and "There is a good choice, there is always something I like, I don't go hungry". However, some people commented "Cooked breakfasts rarely happen". We observed lunch on both days of our inspection. The atmosphere was light and informal, some people had set the tables and staff dished up and brought the meals to most people. People sat where they liked to have their meals, mostly in the dining area. Menu boards showed people the various meal choices.

However, some people had conditions that meant it was difficult to cut food and eat, for example the restricted use of their hands. There was no information for staff on what to do to support people with meals or special cutlery or plate guards to assist people to eat. When observing lunch, one person tipped their plate dropping the majority of food into their lap and onto the floor, their meal was not replaced; however, their food chart recorded that they had eaten their meal. Where adaptive or specialist cutlery or plates may have supported some people to eat, suitable equipment was not assessed or provided.

Appropriate support was not provided to people to eat. This was a breach of Regulation 14 (4)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not have sufficient knowledge or benefit from best practice procedures to ensure some people's health needs were always recognised and followed up appropriately. This meant that some areas of people's care and support did not promote the best outcomes possible. For example, knowledge and procedures around nutrition and hydration did not allow staff to recognise and react to deterioration indicators. Records showed visiting social care professionals had identified significant unaddressed weight loss for some people; this was despite staff recording people's food intake and weight. Fluid charts had running totals of liquid consumed; however, they did not contain information about the expected fluid intake for that individual. Without such information, it is difficult to establish if the required amount was achieved.

Information obtained about people's weight was of limited value because it was not meaningfully linked to their condition, for example, their Body Mass Index (BMI). BMI is a measure that can be used to see if people are a healthy weight for their height. This can help to determine if other measures, such as fortified meals or drinks are need to help people maintain good nutrition, or as an indicator of underlying medical conditions to trigger GP or other referrals. BMI also ties in with a number of established methods to ensure that people are not placed at risk, particularly of malnutrition and skin pressure damage such as ulcers. Staff did not demonstrate a practical understanding of how to recognise and respond to nutrition and hydration needs to ensure that people always received effective care and support. However, since the service was actively working with local authority healthcare professionals to put these practices in place, although not complete at the time of the inspection, we have identified this as an area that requires improvement.

Staff told us they had opportunities to discuss their learning and development through supervision (one to one meetings with their manager). Working with the registered manager also enabled staff to observe the standard of

Inadequate

Is the service effective?

practice required, such as communication with people, infection control, food hygiene and interactions, including treating people respectfully and offering choices. The registered manager kept written records of supervisions and, although basic, staff said they felt supported and thought this system worked well.

Requires improvement

Is the service caring?

Our findings

People told us staff were kind in their approach. People commented their privacy and dignity was respected and staff were caring. To help us evaluate the level of care provided, we also spent time observing staff and people interacting together. Staff were hard working, their interactions were compassionate and well-intended; however, we identified some aspects of care that impacted on people's dignity and independence.

Each person had a care plan, intended to give guidance about the care and support being provided and how they wanted to receive it. Care plans should be designed and agreed with the person through the process of care planning and review. However, it was not evident people were actively involved in their care planning. Care plans did not reflect the how people's interests, aspirations or goals should be met. Care plans were reviewed monthly and although reviews were up to date and had been completed when required, most people had not signed their care records to show staff had discussed their planned care with them or if they had agreed to changes. Some people told us they did not know what their care plan was and were not aware if it had been discussed with them, but told us they were happy with the support they received. People felt happy they could discuss their care and support with staff if they felt they needed to. Some people told us they had done this, however, other people felt they had not had the opportunity or did not know that they could.

The provider had failed to carry out, collaboratively with the relevant person, an assessment of their needs and preferences for care and support. This was breach of Regulation 9 (1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some positive interactions, staff clearly understood the basis of dignity, but on occasion elements of care delivery were task orientated or reactive and suited to the availability of staff. For example, during lunch, although staff were attentive when available, there was little time for interaction other than to attend to a need. On occasion staff were not present to address needs, this resulted in one person tipping their food into their lap and another person falling from their chair. Where people needed support with continence, this tended to take place after the event rather than preventatively or proactively. This did not promote people's dignity, independence or individuality and did not meet evident needs.

The provider had failed to ensure that people were treated with dignity. This was breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we identified some areas that required improvement, we did see staff interacting with people in a kind and compassionate way. When talking to people, staff maintained eye contact and spoke with people at the same level so it was easier to communicate with them or to understand what was being said. Staff had developed rapports with people who responded to staff with smiles and sometimes shared a joke or enjoyed a laugh with them.

Staff spoke positively about the home and told us they enjoyed their work. People appeared comfortable with staff. When supporting people and asking their preferences, staff did so at an appropriate pace, giving people time to form their decisions and express their views. Staff were able to tell us about people's personalities and what they liked and didn't like. One person asked for a coffee, the staff member knew how the person preferred it and confirmed this by asking them.

People were supported to maintain important relationships inside and outside of the service. Relatives and told us they were made to feel welcome when they visited and that visiting times were open and flexible. Visitors told us they could speak to people in private if they wished and gave positive comments about how well staff communicated with them, telling us staff always contacted them if they had any concerns about their family members. None of the visitors we spoke with raised any concerns with us about the service or care delivery.

Some people who could not easily express their wishes, or did not have family and friends to support them to make decisions about their care, were supported by staff and a local advocacy service.

Information was kept confidentially. Care records were stored in a locked room when not in use. Staff understood the importance of privacy and confidentiality and there were policies and procedures to support this.

Requires improvement

Is the service responsive?

Our findings

Our last inspection on 2 October 2014 found the service was not always responsive and identified improvement was required, particularly around people's activities. We asked the provider to take action. They told us the 'weekly activity programme is being constantly monitored reviewed and revised to suit individual needs and capabilities. This will provide guidance to staff with extended walks / drives where suitable and other activities'. During this inspection we found the provider had not taken adequate steps to review and improve activities, therefore they had not met the previous shortfall. We also identified other areas of concern which meant that the service was not responsive.

People told us there was no activity coordinator and staff would try to do something if they had time. Activities were limited, one person said, "There is nothing to do unless you count watching the TV as an activity", another person told us, "We have no transport, staff can't take us out for a drive in their cars, they said they don't have the right insurance". Other comments included "You can do artwork if you like that" and "It's boring". There was a need to give more opportunity for people to follow meaningful activities, such as their individual hobbies and interests. Care planning should consider people's specific activity needs and set out any goals to achieve them. Activity planning is an effective way to increase motivation and retain interest. For example map therapy. This is using maps of people's past home towns and other familiar places as an object of reference, which can prompt reminiscence and emotions. Some sensory activities are particularly beneficial to people living with dementia because they help to evoke memories from smells, for example garden herbs, spices, cooking and baking. This would help staff learn more about people's personality and character, and enhance the day to day communication with people and the quality of care provided.

Activities planned for the week included a daily walk, scrabble, artwork and a quiz. One person attended an activity centre once a week. They told us they enjoyed this and would like to go more often. There was little evidence of activity planning, weekly activity planners held in people's care plans had not been reviewed or updated since 2014.

Pre-admission assessments ensured that the home would be able to meet people's individual needs. These included all aspects of their care and formed the basis for care planning after they moved to the home. Each person had a care plan. Their physical health, mental health and social care needs were assessed and care plans developed to meet those needs. Care plans included information about people's next of kin, medication, dietary needs and health care needs. However, we found that some aspects of care planning were not sufficiently developed or adequately detailed to be individually meaningful. For example, continence support plans focussed on the process for obtaining incontinence pads. They were not personalised specifically for the people they were intended to support, they did not indicate people's daily routines, their preferences for support or the extent to which people may wish to manage their continence themselves. The support plans did not indicate the degree of incontinence or provide guidance about how people may wish their continence to be supported, such as, taking them to the toilet upon waking, prompting them to use the bathroom throughout the day or a plan to consider any other support required. Where a person experienced epilepsy, although seizures were monitored, there was no plan or guidance for staff about how the person needed to be supported.

Individual needs and preferences had not been established. The provider had not designed care and treatment with a view to achieving people's preferences and ensuring their needs were met. This was a breach of Regulation 9 (3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was available to people and visitors to the service. The process was displayed on the notice board and a copy held in people's care plans. People knew how to report a complaint and what the process was. The complaints policy set out how the staff should log a complaint together with various acknowledgement and response timeframes. People and visitors that we spoke with told us they did not have any complaints and did not wish to make any. They told us they knew the staff and registered manager by name and were confident if given cause to complain, it would be resolved quickly. The service was not dealing with any complaints at the time of our inspection.

People's religious and any cultural needs were documented within their care plan. People told us staff were considerate and accommodating of these.

Inadequate

Is the service well-led?

Our findings

Our previous inspection on 2 October 2014 found breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the governance of the service, aspects of staff training and Deprivation of Liberty Safeguards (DoLS). The ratings for the service identified improvement was required for four key domains; overall the service had achieved a rating of requires improvement.

At this inspection, none of the previous requirement actions had been fully met. Systems of audit and governance, although improved in relation to infection control, were ineffective in other areas because people's safety and appropriate treatment was not assured. Induction training was not evaluated and staff were not trained to operate some of the equipment they used. Staff did not have appropriate knowledge about the requirements of the law concerning the Mental Capacity Act and associated Deprivation of Liberty safeguards. Leadership and planning had failed to ensure that the requirement actions issued following our last inspection were fully met.

The quality assurance framework was ineffective; it failed to ensure effective systems and processes were able, at all times, to meet requirements in other parts of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, assessing, monitoring and mitigating the risks relating to people's health, safety and welfare. Accidents and incidents were recorded, but lacked management oversight to ensure that they formed part of the quality assurance systems to identify trends and mitigate risks. Learning from incidents and accidents was not embedded into practice and did not link to risk assessment and care plan reviews. Tests of safety critical fire prevention and detection equipment had not been kept up to date. Staff had recorded excessively high water temperatures but had not taken any action to address this danger. People were placed at risk of unsafe care and practice through a lack of effective audit and checking processes.

Although staff and people told us that the provider visited the home, there was little evidence of formal assessments or their review of the quality of the service provided. The registered manager told us input from the provider was on an informal basis with the majority of communication taking place by telephone or email. The provider, through their assessment processes, had not demonstrated they had the necessary insight to recognise the shortfalls in the care they provided. Consequently they had failed to develop suitable systems to continually evaluate and seek to improve governance and auditing practice.

The registered manager divided her time between managing the service and providing care for people living there. There was no deputy manager position. The only senior carer provided limited hours of support assisting with some management tasks. The level of breaches identified illustrated that there had been a failure in the day to day oversight of the home.

The service lacked management action and a strategy to ensure continuous improvement and development. Staff were unaware of a philosophy of care or values, this made it difficult to develop and adopt a care ethos into working practice and drive forward improvement.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of service was a breach of Regulation 17 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Staff were positive about the registered manager, describing them as "Caring and approachable". All staff thought the manager was supportive and communicated well with them. One person told us "I think all the staff work hard". Another person commented, "The manager does a good job".

People were involved in developing the service and asked their views about the quality of service provided. Examples included taking part in meetings where things like the day to day running of the service were discussed.

There was a clear staffing structure. Staff understood lines of accountability and their individual roles and responsibilities. People knew the different roles and responsibilities of staff and who was responsible for decision making. Observations of staff interactions with each other showed that staff felt comfortable with each other and felt they worked together to achieve common goals.