Mrs P Kent

Kent Lodge Residential Home

Inspection report

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Ratings

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

Overall summary

We carried out this unannounced, comprehensive inspection over two days, on the 9 and 14 September 2015 to check that the provider had made the improvements required following our previous unannounced inspections on the 30 April 2015, 9 March 2015 and the 13 and 17 February 2015.

Following our previous inspections in February, March and April 2015, we asked the provider to take action to make improvements as we found evidence of major concerns at all three inspections in relation to the quality and safety monitoring of the service. There was a continued failure by the provider to ensure that people were protected from the risks associated with improper operation of the premises. This meant that the safety and welfare of people using the service was at risk and the provider was failing to provide a safe service. There was a continued lack of training and supervision support provided for staff. The provider was not meeting the requirements of the law as they did not protect people against the risks of receiving care and treatment that was inappropriate or unsafe.

Summary of findings

We formally notified the provider of our escalating and significant concerns following our comprehensive inspection on 13 and 17 February 2015 and ongoing emerging risk and concerns shared with us by stakeholders. We informed the provider that we were in the process of making a decision with regards to their continuing failure to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We placed a condition on their registration to stop them admitting any further people to their service. We asked the provider to inform us immediately of the urgent actions they would take with immediate effect to protect people and raise standards. We received a response to the urgent action letter on 6 March 2015. This contained a basic action plan but did not address all of the requirements of the urgent action letter. This was further evidence of our lack of confidence in the provider's ability to understand the issues and independently ensure that the service provided safe and effective care.

We carried out a focused inspection on the 9 March 2015 following further concerns identified by the local safeguarding authority and to check if improvements had been made as described in the provider's action plan. At this inspection we continued to have major concerns regarding the lack of action taken by the provider to safeguard people. There was a continued lack of leadership of the service as the service continued not to have a manager registered with the Care Quality Commission (CQC) as is required by law.

A further unannounced inspection on the 30 April 2015 found that some improvements had been made following the recruitment of a new manager. However, we continued to have major concerns regarding the lack of action taken by the provider to monitor the quality and safety of the service, provide training and supervision for staff and safeguard people in the safe management of their medicines as prescribed. Whilst action had been taken by the provider to rectify the lack of hot water to people's bedrooms and install heating to bathrooms, further action was needed to maintain standards of hygiene and improvement of the laundry area.

Visits from environmental health inspectors and a fire officer highlighted a number of areas where action was required by the provider to improve the safety of the environment and protect people from the risk of harm. Although care plans had been produced and people at risk of malnutrition and pressure ulcers had these risks identified with action plans in place to guide staff in the steps they should take to mitigate and reduce risks to people's health, welfare and safety. Action to support people at risk of inadequate nutrition and hydration was not consistent and this continued to place people at risk.

Following our inspection of Kent Lodge on the 30 April 2015 we asked the provider to send us an action plan which would describe the actions they planned to take to meet legal requirements. The provider sent us their action plan which described the action they would take. However, we found that action as described in the provider's action plan to support staff with training, action in response to a recent fire inspection and the monitoring of people at risk of malnutrition and acquiring pressure ulcers had not been taken. This was further evidence of our lack of confidence in the provider's ability to understand the issues and independently ensure that the service provided safe and effective care.

Kent Lodge provides accommodation and personal care support for up to 30 older people who require support including people living with dementia. On the two days of our inspection there were 14 people living at the service.

You can read the reports from our comprehensive inspection carried out 13 and 17 February 2015 and our focused inspections 9 March 2015 and 30 April 2015, by selecting the 'all reports' link for 'Kent Lodge Care Home' o our website www.cqc.org.uk

At this comprehensive inspection 9 and 14 September 2015 we found improvements with regards to the implementation and review of care plans, medicines management and supervision for staff. However, we continued to have major concerns regarding the lack of action taken by the provider to plan for continuous improvement of the service, provide appropriate training for staff and safeguard people from the risk of abuse. The provider continued not to provide staff with training relevant to their role, effective monitoring of people at risk of pressure ulcers, dehydration and failed to take action to deliver care in such a way as to meet people's individual needs and to safeguard them from harm. People's safety had continued to be compromised in a number of areas. This included the continued lack of checks to ensure that staff employed were of good character and safe to work with people who used the service. The provider had continued to frail to identify

Summary of findings

areas of the service that were unsafe and protect people from the risks associated with improper operation of the premises. This meant that the safety and welfare of people using the service was at risk and the provider failing to provide a safe service.

The provider has failed to register a manager with the Care Quality Commission (CQC) for four years. The current manager had been in post since March 2015. 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 provider oversight and we found concerns about the ongoing financial stability of the service. We were not assured that the provider had taken all reasonable steps to meet the financial demands of providing a safe and effective service as described in their statement of purpose to the required standards.

The provider did not operate a safe and robust system when recruiting staff. Checks on the suitability of staff including Disclosure and Barring (DBS) checks had not been carried out on all staff.

Although we found some improvement at this inspection with staff provided with opportunities to receive regular supervision and attend team meetings, we found that the provider did not have a systematic approach to determine their training and development needs. Staff continued not to be provided with the training required, relevant to their roles which would provide them with the skills and knowledge to keep people safe. This failure to consider, plan and provide for the range of skills required put people at risk of their health, welfare and safety needs being met and keep them safe at all times.

At our previous inspection 30 April 2015 we found shortfalls in the support of people at risk to enable them to receive adequate nutrition and hydration. We found at this inspection people's weight was monitored and referrals were made to the GP or dietician as necessary. However, we found that people who had been assessed as at risk of dehydration and acquiring pressure ulcers were not consistently monitored to ensure that their health, welfare and safety needs were met and this placed people at risk.

Where visits from environmental inspectors and a fire officer highlighted a number of areas where action was required by the provider to improve the safety of the environment and protect people from the risk of harm, there was a continued lack of action to mitigate these risks. Fire doors continued to be wedged open. Food and hygiene safe practices continued to be ignored by staff with these designated responsibilities to safeguard people from the risk of harm.

People continued to be at risk as there was a continued failure to ensure that people were protected from the risks associated with improper operation of the premises.

During this inspection we identified a number of breaches of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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. People had been placed at continued risk as the provider did not operate and effective system for management of the premises. Not all areas of the service had been adequately maintained.

The provider had failed to respond to improve the safety of the environment to protect people from the risk of harm.

The provider did not operate a safe and robust system when recruiting staff. Checks on the suitability of staff including Disclosure and Barring (DBS) checks had not been carried out on all staff.

Is the service effective?

Requires improvement

The service was not effective. The provider continued not to ensure that the care and treatment for people at risk of falls, dehydration and acquiring pressure ulcers was sufficiently monitored.

Staff continued not to be provided with the training required, relevant to their roles and provide them with the skills and knowledge to keep people safe.

Care plans had been improved to provide staff with the guidance they needed to provide safe care and treatment that met people's needs.

Is the service caring?

Requires improvement

The service was not consistently caring because we found differing levels of kindness and compassion shown by staff towards people. Whilst some staff showed kindness, compassion and promoted people's dignity and treated them with respect this was not consistent across the staff team.

Is the service responsive?

Requires improvement

The service was not consistently responsive because action to protect people from the risk of falls, inadequate hydration and acquiring pressure ulcers was not consistent to mitigate and reduce the risks to people.

People told us they had confidence in the manager that they would listen to their concerns. However, people were not involved in planning improvement of the service and their concerns regarding the safety of the environment responded to.

Is the service well-led?

Inadequate

The service was not consistently well led because the provider had continued not be actively involved in carrying out any quality and safety monitoring of the service.

Summary of findings

The manager demonstrated steps taken to improve the service was limited with a lack of resources to provide for continuous improvement of the service and keep people safe.

There was a lack of provider oversight and we found concerns about the ongoing financial stability of the service. We were not assured that the provider had taken all reasonable steps to meet the financial demands of providing a safe and effective service.

Kent Lodge Residential 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days on the 9 and 14 September 2015 and was unannounced.

The inspection team consisted of two inspectors, a pharmacy inspector and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had personal experience of caring for people with dementia care.

Before the inspection we reviewed the information available to us about the service, such as notifications. A notification is information about important events which the provider is required to send us by law. We also reviewed information about the home that had been provided by staff and relatives.

During the inspection we spoke with eight people who lived at the service, two relatives, two senior care staff, four care staff, one domestic, a cook and the manager. We carried out observations of the interactions between staff and the people who lived at the service throughout the day.

We reviewed the care records and risk assessments for four people. We looked at records relating to the management of people's medicines, staff recruitment, staff training, staff rotas and systems for monitoring the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection of Kent Lodge on 30 April 2015 and also our inspections in February 2015 and March 2015 we found that the provider had continued to fail to take action to ensure people's health and welfare was not put at risk. We continued to have significant concerns as medicines were not managed safely to ensure that people received their medicines as prescribed. The premises had not been maintained and people were not safeguarded from the risk of harm.

Whilst we found some improvement at this comprehensive inspection 9 and 14 September 2015 in relation to the management of people's medicines, we found ongoing concerns and that further work was required to ensure the provider was meeting the legal requirements. For example, the provider failed to operate a safe and effective recruitment system, provide staff with safeguarding training relevant to their role and a continued failure to ensure that people were protected from the risks associated with improper operation of the premises.

We found that the provider continued to put people at risk because the provider did not take steps to carry out Disclosure and Barring (DBS), criminal records checks prior to staff starting their employment. At our inspection in February 2015 we had identified three members of staff who had not had a DBS check carried out before they started their employment at the service. At this inspection the 9 and 14 September 2015 we found that only one out of the three staff previously identified was still working at the service. The provider had failed to take action as the DBS check for this one remaining member of staff had still not been applied for.

A visit to the service from the local safeguarding authority in May 2015 had also identified shortfalls in the provider's lack of a safe and effective recruitment system. The outcome of their visit was the implementation of an agreed protection plan. The provider had agreed that they would ensure that DBS checks would be taken as a matter of urgency and risk assessments carried out with actions taken to safeguard people recorded. We found action had not been taken as agreed within the protection plan to implement safe and robust recruitment procedures to safeguard people who used the service.

We also found that two other staff where DBS checks had identified previous criminal convictions, the provider had failed to carry out any risk assessment which would identify their decision making process for assessing whether or not these staff were of good character, honest, reliable and trustworthy. This demonstrated a continued lack of action taken by the provider to safeguard people.

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

Staff had not received safeguarding training relevant and at a suitable level for their role. Staff told us they had not received training in safeguarding people from the risk of abuse. Staff also told us they were not aware of any whistleblowing policies and procedures. All staff we spoke with said they would report bad practice to the manager if they witnessed it. However, one senior member of staff, responsible for leading shifts and on occasions the person in charge and responsible for responding allegations of abuse was not able to tell us what action they would take other than speaking to the manager or the provider. They did not demonstrate any awareness of and neither the knowledge of how to process referrals to the local safeguarding authority in accordance with local protocols. Staff were not aware of any safeguarding policies or procedures in place with guidance to prevent abuse.

Since our last inspection of Kent Lodge in April 2015 the local safeguarding authority told us of two incidents where it was alleged people's money had been stolen. On both occasions the provider had reimbursed the money but had failed to notify relevant safeguarding authorities of these incidents. This meant that the provider did not ensure that they had and implemented, robust procedures and processes to make sure people and their property were protected.

This demonstrated a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found at this inspection a continued failure to ensure that people were protected from the risks associated with improper operation of the premises.

A visit from a fire officer in April 2015 identified a number of deficiencies. For example, the fire alarm system was found to be inadequate for the type of premises, emergency

Inadequate

Is the service safe?

routes and exits from some bedrooms were in excess of the recommended distance for escape in event of a fire and a number of exit doors were key-operated and not easily opened without the use of a key or keycode. Testing of emergency lighting and firefighting equipment had not been tested as is required by law. Whilst action had been taken to service the fire alarm system and emergency lighting we found fire doors continued to be wedged open contrary to fire regulations with people's personal ornaments, commodes and wedges. As a result risks to people persisted; fire doors must be kept close in order to limit the spread of a fire. Wedging them open presents no barrier to fire and will allow a fire to spread quickly. The provider had not taken action to protect people from risks associated with improper operation of the premises. The manager was not aware of any plans in place to comply with the fire officer deficiencies notice.

We also at our previous inspections in March 2015 and April 2015 identified concerns with regards to people's access to the boiler room, sluice room and laundry room where chemicals were stored. This had also been identified as a risk to people's safety following a visit from Environmental Health officers (EHO) on the 6 March 2014. We had requested a lock be placed on these doors to prevent people living with dementia from accessing these potentially hazardous areas. The provider had taken action to fit a lock to the sluice room but no lock had been fitted to the laundry room and neither the boiler room. We observed both the laundry and boiler room doors to be open for people to access. This meant that the risk to people's safety remained as access to these areas and in particular the laundry room where laundry chemicals were stored had not been restricted.

No action had been taken to improve the laundry room as identified at our previous inspections in March and April 2015. The laundry room floor and walls remained insufficiently sealed to enable staff to clean and prevent infection. There was a wash hand basin with liquid soap but not paper towels to dry hands. Staff did not have access to a tumble dryer which meant that staff relied on good weather to dry people's laundry.

Two cracked and split wooden toilet seats had not been replaced and continued to remain a hazard to people from pinching to the skin and harbouring of bacteria as they could not be sufficiently cleaned.

We found that the provider failed to take action to address a number of concerns that had been identified by EHO inspectors with regards to the safe storage and handling of food. The manager had carried out regular audits of the kitchen. These showed us that staff continued not to implement food and hygiene safety procedures as required by law to keep people safe.

When we arrived at the service we observed two care staff and a senior carer were not wearing aprons whilst in the kitchen, but promptly started to use these when they saw inspectors. We looked in the fridge at food stored there. There were a number of food items without covers or dates on them. The chef informed us that some items were staff food and were not to be served to people living at the home. There was made custard in a jug and grated cheese, both were covered with cling film but not dated. The chef indicated these were for people living at the service and disposed of both immediately. We looked at records and found that not all staff using the kitchen that day had been provided with training in basic food hygiene.

We looked at the cleaning schedules completed daily and weekly. There were gaps in both these documents that showed that a cleaning system was in place but had not being regularly followed. For example, the previous day's cleaning schedule had not been completed. The manager had recently implemented regular audits of the kitchen and had identified concerns with kitchen staff regarding the lack of cleaning, storage of food and completion of records. This did not reassure us that the risk to people's health, welfare and safety had been mitigated as food safety standards had not been maintained to the required standard.

This demonstrated a continued breach of Regulation 15 (1)(a) (b) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found improvements in overall care planning with care plans in place which included personalised risk assessments for each person. These included the risks associated with people being assisted to move around the service, eating and drinking including assessing the risk of malnutrition and also the risk of developing pressure ulcers. However, where two people had been identified as at high risk of developing a pressure ulcer and required repositioning every two to three hours as they were unable to move themselves staff had failed to reposition these people according to their plan of care. For example, one

person we observed sat in the lounge from 09:30. They sat in the same position with no action taken by staff to reposition them until 16:15pm when staff supported this person to lay on their bed. The other person identified we also observed sat in a lounge chair from 09:30 until 17:30 without action taken by staff to reposition them in accordance with their plan of care. Both people were sat on hoist slings which would counteract any benefit of pressure relieving equipment placed within the chairs. We brought this to the attention of the manager who told us that people would have been repositioned by staff and the 'exercise chart' would have been completed to evidence this. We looked at these records where staff would have recorded to evidence action to reposition people and found that these had not been completed throughout our visit. We were not reassured that people had been repositioned in accordance with their plan of care. Staff and the manager told us that none of the staff had received any training in recognising, prevention and care of pressure ulcers. This meant that action had not been taken to mitigate the risks of people from developing pressure ulcers.

We looked at accident and incident reporting. We saw that one person had experienced five falls over a recent period of five months. Although these incidents had been recorded, there was no recorded evaluation and evidence of any prevention measures put in place to mitigate further risks of harm from falls. We therefore believed this person to be at risk and discussed this with the manager.

This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspections in February 2015 and April 2015 we found the provider had failed to take action to manage people's medicines safely as there was a lack of systems in place which would enable effective monitoring of medicine stocks and audits of administration records. We found some improvement at this inspection 9 and 14 September 2015. The manager had implemented a new medicines management policy. This made clear to staff the process to follow to ensure medicines were administered safely to people. Medicines errors were clearly documented on newly implemented incident forms. We found appropriate arrangements were in place for obtaining medicines. Medicines were stored safely and securely. The manager had implemented twice weekly audits to check administrations of medicines were being recorded correctly. The stock balances for medicines not in the monitored dosage system were recorded daily and the sample we checked was correct. However, not all staff had been trained in the safe administration of people's medicines including night staff. This impacted on people's ability to access pain relief medicines as and when required during the night time period.

People told us they received their medicines on time. A relative told us, "I know all is OK, they give [my relative] their medication when it is needed. Never any problems there". We spoke to two staff members about medicine administration.

One staff member explained that one person we observed having their medicines covertly administered within their food had capacity to consent to their medicines being administered in this way. However, we found their care plan described them as not having capacity to consent and no best interest decisions had been made by those qualified to do so in accordance with the provider's medication policy. When our pharmacy inspector spoke with senior staff during the second day of our inspection staff told them that there was no one who currently had their medicines covertly administered. The provider's medicines management policy described it necessary to distinguish between the concealing of medication in food and drink and the need to take action to assess the person within the framework of the Mental Capacity Act 2005 with action to ensure a best interest assessment was carried out by those qualified to do so. We were therefore not assured that action had been taken to appropriately asses this person within the framework of the Mental Capacity Act 2005 as described within the providers medicines management policy.

This demonstrated a breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views regarding the availability of staff. Whilst some people said the service could do with more staff others told us there was sufficient staff to meet their needs. Comments included, "The staff will sit down with you for a chat but it depends on workload and the number of staff available", The staff are rather busy to chat", "I don't think there is enough staff in the daytime, they've got staff shortages you know." However, other people and relatives told us, "The staff do have time to chat. They do their jobs

Inadequate

Is the service safe?

then sit down with people. They are like real friends not just staff", "Yes I use my call bell and they come straight away" and "I do have a call bell with me during the night and if I call they do come as quick as they can."

We observed that staff were stretched to meet all the demands placed upon them during our inspection. This resulted in a senior carer leaving her shift 30 minutes late as they had not completed care records.

Requires improvement

Is the service effective?

Our findings

At our previous inspection of Kent Lodge on 30 April 2015 and also our inspections in February 2015 and March 2015 we found that the provider had continued to fail to take action to provide suitable arrangements for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided to them. Staff continued not to be provided with the training relevant to their roles and responsibilities. This put people at risk of not receiving safe care and treatment and their needs met by a skilled and competent staff team.

Although we found some improvement at this inspection 9 and 14 September with action taken to provide staff with opportunities to receive regular supervision and attend team meetings, the provider continued not to have a systematic approach to determine their training and development needs. This failure to assess, plan and provide for the range of skills and knowledge required put people at risk of their health, welfare and safety needs not being met and action taken to keep them safe at all times.

Staff told us they had received some in-house training provided by the manager. For example, in recognising and responding to the needs of people living with dementia. 50% of staff had attended dignity training provided by the local authority and senior staff training in safe administration of medicines However, discussions with the manager and a review of staff records showed us that only 50% of staff where this was required had received training in the safe moving and handling of people. Only 50% of staff had attended training in recognising signs of malnutrition and guidance in how to use malnutrition screening tools. Not all staff using the kitchen and involved in the preparation of food had been provided with training in basic food hygiene. Staff had not received training relevant to their roles to enable them to understand their roles and responsibilities with regards to safeguarding people from the risk of abuse including reporting incidents and allegations of abuse, the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS).

At this inspection we identified shortfalls in the monitoring of people at risk of falls, people at risk of acquiring pressure ulcers and those at risk of dehydration. Training had not been provided for staff to equip them with the skills and knowledge they required to prevent people from the risk of falls and recognise the signs of and protect people at risk of acquiring pressure ulcers.

The manager told us that there was no budget or financial planning for staff training and this limited their ability to plan and provide for staff training and development needs and meet legal requirements. This lack of planning and available resources limited and prevented staff from obtaining training and further qualifications appropriate to their role. This impacted on their ability to gain the required knowledge and skills to respond to people's needs and keep them safe.

This demonstrated a continued breach of Regulation 18 (1) (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff routinely ask people for their consent to support them with care. We found in care plans that documents had been designed and signed by people using the service that showed they had been consulted and agreed with their plan of care. Care plans contained information with regards to relatives who had power of attorney in relation to care and welfare. Other documents showed us that they were consulted and involved in decisions of care and welfare matters.

We found inconsistent information within people's care plans when assessing people's ability to consent and any restrictions on their freedom of movement. The manager told us that a DoLS application to the local safeguarding authority to deprive a person of their liberty and to keep them safe had been submitted. The local safeguarding authority had advised appropriate measures were already in place to balance the freedom and safety of the person. However, for another person the manager was unclear as to any application that had been made. We found that an urgent authorisation had expired and a standard authorisation application had been made. However this had not been followed up and so no best interest decisions were considered on behalf of this person. There was a lack of clarity and knowledge on behalf of the manager in relation to any deprivation of people's liberty and this put people at risk of not having their best interests considered when their movement was restricted by those qualified to do so and meet legal requirements.

Requires improvement

Is the service effective?

At our previous inspection 30 April 2015 we found shortfalls in the support of people at risk to enable them to receive adequate nutrition and hydration. We found at this inspection people's weight was monitored and referrals were made to the GP or dietician as necessary.

We received mixed opinions regarding the quality and choice of food people were provided with. Comments included, "The food is very good", "I like my food to have a bit more flavour with maybe some spice and herbs but you have to go with the majority and be grateful for what you receive" and "I don't have much of an appetite, but they are always coming round with drinks and biscuits. The food here is lovely." One relative was aware that their relative had lost weight. They believed staff were encouraging and supporting their relative with eating. However, they were not aware that the dietician had been consulted and had given specific dietary advice. In relation to one person we tracked, when they had arrived at the service they had been assessed as malnourished. Since arriving at the service they had increased their weight by 10kg. Therefore the assessments and actions to increase this persons eating and drinking had the desired effect in making them a healthier weight.

We observed two people where their intake of fluid was being monitored. In both cases fluid charts were not adequately completed to show that people had consumed sufficient fluids to prevent them from becoming dehydrated. Fluid charts did not record the assessed optimum amount of fluids that would be required for that person to drink within 24 hours. Records were confusing and staff recorded differing ways to measure. For example staff recorded, millilitres, sips, a glass and cups to record the amount of fluid consumed. In a number of entries they recorded 'drank all blackcurrant'. However, none of the records calculated how much a person had consumed within a 24 hour period to determine if they were sufficiently hydrated. We determined that two people, based on records alone may have been left dehydrated. For example, one person had on one day recorded fluid of 35 mls in total and 2 ½ cups, the next day they had 205mls, 3 sips and ½ cup. The following day they were recorded as 'asleep' or 'refused'. We were therefore not assured that people were monitored to ensure that they were sufficiently hydrated to meet their health and welfare needs.

We spoke with the chef who told us they were aware of those people who required a different texture of food and how to prepare this appropriately. They told us they were aware of those people who were diabetic or those assessed as at risk of malnutrition. Whilst there was a degree of daily choice from the menu the menu had been planned by the provider and shopping for food was delivered from a wholesaler and was ordered the previous week. The food provided during our visit was not the food as described on the planned menu. People told us they were not always aware of what meals they would be provided with as the menu did not always match with what was provided. We found that choice could further be enhanced if people were involved in the planning of menus.

This demonstrated a continued breach of Regulation 14 (1) (2) (4)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative said, "I can sleep at night knowing [my relative] is well looked after. The GP visits if needed as they look after all that. The chiropodist will come this Friday." Care plans recorded that people had access to a dentist and optician.

We spoke to a visiting health professional. They told us, they had been aware that there had been previous concerns regarding a lack of referring people at risk of pressure area concerns in a timely manner but said that recently staff had referred people and that they had a good rapport with staff in the service.

Requires improvement

Is the service caring?

Our findings

People were in the main positive about the care they received and all told us the staff were kind and caring. Comments included, "I like it here. I would not like to go anywhere else", "Most of them [staff] are fairly dedicated, giving care which is pretty good", "Those that have been here the longest are the most proficient. The young ones are not so competent and caring", "I have a laugh with them [staff]" and "The care is pretty good, they care very much."

We observed interactions between staff and people who used the service. We found differing levels of kindness and compassion shown by staff towards people. We saw one member of staff comfort and listen to a person whilst being distressed. They brought them a blanket to place on their lap, but before going reassured them they were coming straight back and why they were going. In contrast we observed a staff member supporting a person eat their meal. Whilst the staff member was attentive to helping the person eat, with a good pace at refilling their fork, there was no verbal encouragement or interaction. The interaction was neutral and lacked any warmth and empathy. We later overheard this same member of staff talking in an abrupt manner to one person in response to their requests for support.

People told us their privacy and dignity was protected when supported with their personal care needs. However, one person was observed to be sat in the lounge wearing only a dressing gown. This person's dignity was compromised due to an ill-fitting dressing gown and one member of staff attempted to preserve this person's dignity. However, there was no further suggestion of this person being provided with a blanket or other suggested action to protect this person's dignity and prevent further embarrassment for the individual or other people also sat in the lounge area. We discussed the interactions of concern with the manager.

There were areas of good practice in relation to supporting people express their views. Some people had been consulted in the development of their care plans and given opportunities to make decisions about how their care was to be delivered. Relatives told us the manager kept them informed and up to date with regards to changes in the health and wellbeing of their relative. One relative told us how they were part of the decision when it came to their relative moving room as the person did not have capacity to express their views. Another relative told us, "They ring us and tell us if things have changed." However, people told us they were not routinely consulted and involved in the planning of menus, activities and planning for improvement of the service. The manager told us that there had been two recent relatives and residents meetings. Minutes from these meetings had not been recorded.

Requires improvement

Is the service responsive?

Our findings

During our inspections 13 and 17 February 2015, 9 March 2015 and 30 April 2015 we found that people did not always receive personalised care that was responsive to their needs. Care plans did not contain enough information about people's needs for staff to deliver responsive care.

At this comprehensive inspection 9 and 14 September 2015 we found improvements in the assessment and recording of people's needs and the quality of care planning.

We spoke to staff about how they supported one person living with dementia whose needs were changing. Staff said they had researched on the internet about doll therapy and were obtaining a soft bodied doll. They had already purchased some baby clothes and these along with other items had proved helpful in supporting this person with they became distressed. Staff also told us that recent training provided by the manager had given them the knowledge they needed to understand the needs of people living with dementia. In addition the staff had contacted a local specialist health team who were visiting that day to assess and determine what additional support could be offered. We observed staff spending one to one time with the person throughout the day to reassure them.

Relative's told us they were very satisfied with the support and response of staff to their relative's needs. They told us that they had been consulted about changes and had been involved in decisions regarding the care of their relative. They told us the service had accommodated their relative well especially in relation to them having their own furniture, possessions and recognisable bed in their room.

We saw that comprehensive information in relation to the care of people diagnosed with diabetes and epilepsy was now recorded in care plans. This meant staff were provided with information and guidance in how best to respond to a change in a person's health. These were based upon assessments completed and knowledge of the individuals concerned. One care plan for a person living with dementia contained a detailed life history which provided staff with the information they needed to understand and better support that person.

We saw that people were supported to follow their personalised interests. One person told us that the hairdresser came every week and how they had their hair done regularly. Another told us that they had been out the previous day to a local club that they regularly attended. Another person had an adult therapy colouring book that they were enjoying completing and told us how it was calming for them to do.

Relatives told us that they were not aware of any formal complaints procedure but that the manager responded to any concerns that they might have. One relative told us, "There is no need to complain to the manager as everything has been addressed. I'm confident he would resolve things." We asked the same person if there was anything that could be done to improve the service. They told us access to the outside spaces was, "Very difficult and the paths are not level." They said they had mentioned this to the provider but that no action had been taken to resolve this and this remained a risk to people's access to the outside and their safety.

Inadequate

Is the service well-led?

Our findings

At our previous inspections in February 2015, March 2015 and April 2015 we found that there was a lack of action taken by the provider to assess environmental risks to people and others. A review of the service's fire risk assessment had been carried out and staff provided with emergency evacuation procedures to follow in the event of a fire. Personal evacuation plans had been recorded for each person who used the service with actions to take in the event of a fire, flood or power failure. However, we found that further work was required to risk assess all areas of the service which posed a risk to people including staff and others. For example, hazards remained in relation to the laundry area, fire safety and staff recruitment.

Following a visit from a fire officer the provider had been issued with a notice of deficiencies on the 29 April 2015. They sent us a copy of the report they had sent to the provider with requirements and timescales for action to be completed by January 2016. A number of areas had been identified where action was required by law. For example, the fire alarm system was found to be inadequate for the type of premises, emergency routes and exits from some bedrooms was in excess of the recommended distance for escape in event of a fire and a number of exit doors were

key-operated and not easily opened without the use of a key or keycode. Testing of emergency lighting and firefighting equipment had not been tested as is required by law. The manager told us that steps had been taken to service the fire alarm system, emergency lighting and electrical portable appliance testing. However, no other work had been completed and the manager was not aware of any actions planned by the provider to do so.

The manager had implemented some quality monitoring of the service for example, audits of weekly fire bell testing, water temperature testing, medicines audits and monitoring the standard of cleaning in the kitchen. However, further work was needed to ensure that audits of care plans and repositioning records was maintained to ensure that risks to people were monitored and action taken to protect people against the risks of receiving care and treatment that was inappropriate or unsafe.

Following shortfalls identified at pour previous inspections in February, March and April 2015 the provider agreed a protection plan with the local safeguarding authority to implement robust procedures when recruiting staff and to carry out Disclosure and Barring (DBS) checks on staff who had previously been employed without these checks having been carried out. We found that the provider had failed to take action as they had previously agreed. The provider did not monitor the progress against this plan to improve the quality and safety of the service, and take appropriate action without delay where progress was not achieved as expected.

The manager told us that there had been recent residents and relatives meetings which had taken place since our last inspection in April 2015. Recorded minutes from these meetings had not been taken and so we were unable to view the content which would evidence that feedback had been listened to recorded, actions agreed and responded to as appropriate. However, people told us the manager was visible in the service and approachable should they wish to raise any concerns.

The provider visited the service on a weekly basis. However, they continued not to carry out any quality and safety monitoring of the service.

This demonstrated a continued breach of Regulation 17 (1) (2)(a) (b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were not assured that the provider had taken all reasonable steps to carry on the regulated activity in such a manner as to ensure the financial viability of the service. The manager told us that where a relative of the provider had previously carried out regular visits to the service to attend to minor maintenance tasks such as replacing light bulbs, garden and decorating work these visits had not taken place for a significant period of time. We found areas of the service in need of decoration, replacement of carpets and rooms without working light bulbs and action not taken to replace broken wooden toilet seats. When asked, the manager told us they were not aware of any maintenance, renewals budgets to replace equipment, furniture and decoration. Petty cash that had previously been available for the manager to replace items was now not made available for them to purchase items in need of replacement. Staff told us that when required they had paid from their own money for items such as food and stamps and were reliant on the provider reimbursing them for these items in a timely manner.

Inadequate

Is the service well-led?

Staff expressed concerns regarding the provider and their approach towards staff. Staff told us that the provider had made changes to their annual leave policy without consulting with staff regarding these changes. This had resulted in some staff having pay deducted from their salary without prior notice.

This demonstrated a breach of Regulation 13 (1)(a) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The provider has failed to register a manager with the Care Quality Commission (CQC) for four years. The current manager had been in post since March 2015. All of the people we spoke with including staff and relatives were complimentary about the manager. Staff told us, "He has brought stability to the place", "He is always available and easy to talk to" and "We are confident in him to get things done."

The manager told us that there had been recent residents and relatives meetings which had taken place since our last inspection in April 2015. However, recorded minutes from these meetings had not been taken and so we were unable to view the content of issues discussed and neither any actions agreed following these meetings. People told us the manager was visible in the service and approachable should they wish to raise any concerns.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Actions taken to mitigate risks for people from acquiring pressure ulcers and dehydration were not always followed and monitored effectively. The provider failed to ensure arrangements for giving medicines covertly were in accordance with the mental Capacity Act 2005. There was a continued failure by the provider to ensure that people were protected from the risks associated with improper operation of the premises. Regulation 12 (1) (2)(b)(d)

The enforcement action we took:
We have taken enforcement action and will report on it when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The provider failed to implement systems and processes in response to allegations of financial abuse. The provider failed to provide staff with training in responding to allegations of abuse relevant to their roles. Regulation 13 (1) (2)(3) **of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The enforcement action we took:
We have taken enforcement action and will report on it when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Enforcement actions

Diagnostic and screening procedures Treatment of disease, disorder or injury	How the regulation was not being met: There was a continued failure to ensure that people were protected from the risks associated with improper operation of the premises. Risks to people's health, welfare and safety had not been mitigated as food safety standards had not been maintained to the required standard. **Regulation 15 (1)(a) (b) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The enforcement action we took:
We have taken enforcement action and will report on it when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider failed to operate effective systems and processes to make sure they assessed and monitored the quality and safety of the service. The provider failed to take action without delay protection plans ass agreed with the local safeguarding authority. **Regulation 17 (1) (2)(a) (b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The enforcement action we took:
We have taken enforcement action and will report on it when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider failed to support staff to obtain training relevant to their role to meet people's needs and keep them safe from harm. **Regulation 18 (1) (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We have taken enforcement action and will report on it when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: The provider failed to take appropriate action if people were not drinking sufficient amounts in line with their assessed need. People should be able to make choices about their diet and involved in planning menus. **This demonstrated a continued breach of Regulation 14 (1) (2) (4)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The enforcement action we took:
We have taken enforcement action and will report on it when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider did not establish and operate effectively a safe recruitment process when employing staff. They failed to make every effort to gather all available information to confirm that staff were of good character and trustworthy. Regulation 19 (2)(a)(b) (5)

The enforcement action we took:
We have taken enforcement action and will report on it when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 13 CQC (Registration) Regulations 2009 Financial position How the Regulation was not being met:

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	The provider failed to take all reasonable steps to meet the financial demands of providing a safe and appropriate service. Regulation 13 (1)(a) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The enforcement action we took:
We have taken enforcement action and will report on it when the action is complete.