Four Seasons (No 10) Limited

Murrayfield Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18 and 19 October 2016 and was unannounced. Murrayfield Care Home provides accommodation, nursing and personal care for a maximum of 74 people, some of whom are living with dementia. At the time of the inspection there were 67 people using the service.

There was a registered manager in post. However, the registered manager was not available on both days of the inspection and the inspection process was supported by the deputy manager and the provider's area manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, one week after the inspection we learnt that the registered manager had left their position and that the home did not have a registered manager in place.

At our last inspection in September 2015, we found that some aspects of medicines management were not safe. The provider was also found to be in breach of Regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to the lack of documentation to show how staff were supported effectively through supervisions and appraisals. There was also no documentation to show that the service had completed any quality assurance audits

Due to the serious nature of the breach of Regulation 12, relating to unsafe medicine management, we had taken enforcement action against the provider. We issued a warning notice to the provider detailing the issues we found and requiring them to become compliant within a specified timescale. An unannounced focused inspection took place in December 2015 to check that this significant breach of legal requirements had been addressed. During the focused inspection, it was found that all legal requirements for the safe management of medicines had been met.

During this inspection we found that, although the service had made some improvements in relation to previous issues that we had identified, a range of other serious concerns were found in relation to the care and support that people received.

Care staff did not understand what person centred care was or how to support people living with dementia even though specific dementia awareness training had been delivered recently within the home. Care plans did not always have a life history booklet completed about the person and significant details about the person were not always recorded in the care plan.

Scheduled activities did not always take place. Very little interaction, activity or stimulation was noted to be initiated by care staff on duty and people were seen to be taken to the lounge and positioned to watch television throughout the day. Care staff did not appear to be caring and responsive to people's mental and emotional well-being.

Over both days of the inspection, we observed people experiencing a poor mealtime and dining experience, which did not promote well-being and independence. There were no menus available for people to know what their meal was going to be on the day. People who required assistance with their meals were seen to be left waiting for prolonged periods of time before they were supported. Care staff were noted to have poor awareness of what was on the menu and on occasions did not offer people any choice of what they would like to eat.

Risks associated with people's care and support needs had been identified and these had been assessed, giving staff instructions and directions on how to safely manage those risks. However, where records were needed to be kept in relation to monitoring fluid intake, these had not been completed to ensure that this area was safely monitored and that people were protected from the identified risks. Care staff were also unable to tell us which people's fluid intakes were being monitored.

Poor standards of cleanliness were noted in various areas of the home. The service had a housekeeping team in place where cleaning schedules were followed. However, these were observed to be ineffective as specific areas were observed to be extremely dirty. This included certain food preparation areas, bathrooms and shower rooms.

On the first day of the inspection we found a number of chemicals, one without a sealed lid, loose medicated creams and mouthwashes in the communal bathroom areas which were easily accessible to people to pick up and possibly consume. This is of particular concern where people are living with dementia.

Although people and relatives confirmed that people felt safe at the home and with the care and support that they received, care staff that we spoke to were unable to explain to us what was meant by the term 'safeguarding.' Care staff could not describe the various types of abuse and were unable tell us the actions that they would take if abuse was suspected. Care staff were also unable to explain their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how this affected the care and support that people received.

At the inspection in September 2015 we identified that there was gaps in information confirming training that care staff had completed. During this inspection, we saw records confirming that all staff had received the appropriate training required to fulfil the requirements of their role. However, this training was not effective as care staff were unable to tell us about what safeguarding, whistleblowing and MCA meant. Care plans that we looked at did not include information to show that people had consented to their care. Where a person was unable to consent to their care, there was no documentation that relatives or other people involved in the person's care and support had been asked to consent on their behalf.

Safe medicine management systems and process were in place to ensure that people received their medicines safely and as per their needs and requirements. The service had ensured that issues identified at the inspection in September 2015 were addressed and the improvements made were sustained.

Care staff told us that they received regular supervision and felt supported in their role. However, we were unable to evidence and check during the inspection to confirm this. Completed supervision and appraisal forms were not available or contained within care staff personnel files.

People and relatives had mixed views about the quality of the food that was provided at the home. Some people and relatives told us that the food was of good quality and some told us that the food was not very good and very little choice was offered. On the second day of the inspection, we sampled the food that was

offered to people and found it to be appetising and appropriately presented.

People, relatives, care staff and external health care professionals were positive about the management structure that was in place and the way in which the home was managed. They told us that the registered manager and deputy manager were always available to deal with any queries or complaints.

During the inspection in September 2015 we found that although the service carried out medicine audits, there was a lack of evidence to show that other areas of the home or service provision had been checked to ensure management had oversight of the home and the service that it provided. This included areas such as housekeeping, infection control, care plan and care staff file audits. During this inspection, we found that although a number of systems had been in place to monitor service provision, these were not always effective and did not highlight the issues that we had identified during this inspection.

The provider demonstrated safe recruitment processes were in place to ensure that each person employed at the service was safe to work with vulnerable adults. This included criminal record checks, identification verification, visa verification and reference requests confirming staff conduct in previous employment.

At this inspection we found breaches of Regulation 9, 10, 12, 14, 15, 17, 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to people not receiving person centred care as well as poor use of fluid intake charts so as to minimise risks associated with poor fluid intake. Breaches were noted in relation to poor mealtime experiences, the cleanliness of the home and the risks associated with leaving chemicals and medicines within easy access of people especially those living with dementia, ineffective quality audit systems and care staff's poor understanding of key areas such as safeguarding and MCA 2005. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The home was found to be dirty especially in specific areas such as food preparation areas, bathrooms and shower rooms.

Chemicals, loose medicated creams and mouth washes were found in bathrooms and shower rooms where people, especially those living with dementia, could access and possibly consume.

Fluid intake charts were not completed effectively in order to mitigate risks associated with poor fluid intake and de-hydration. Care staff were not aware of which person's fluid intake needed to be monitored.

Although people and relatives told us that they felt safe with the care staff and the support that they received, care staff were unable to define the meaning of safeguarding and were unable to list the different types of abuse and the actions they would take to report suspected abuse.

Safe medicine systems and processes were in place ensuring that people received the medicines they required in a safe and timely manner.

Safe recruitment practices were followed ensuring all appropriate checks were completed prior to care staff starting work at the service.

Is the service effective?

Requires Improvement

The service was not always effective. Although care staff had received the required training to enable them to carry out their role, care staff could not demonstrate their knowledge and understanding in specific areas such as safeguarding, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Care plans did not evidence that people had consented to their care and support. Where people were unable to consent and sign their care plan, there was no evidence that relatives or an advocate had consented to the persons care on their behalf.

People and relatives gave mixed feedback about the quality of food that they received. We observed that care staff did not know what food was available on the menu for the day and did not always offer choice to people.

People had good access to health care services and received appropriate care and treatment when required.

Is the service caring?

Requires Improvement

The service was not always caring. Care staff did not appear to be caring and responsive to people's mental and emotional well-being. People did not have their wishes and choices respected and staff ignored people's requests.

People were not observed to be involved with making day-to-day decisions about their care and support. Care was seen to be delivered as a task to be done to people and not together with people.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not always consistent with the information that was contained within them. Some care plans were noted to be person centred and gave information about the person, their choices and decisions about how they wish to be supported.

Planned activities did not always take place. People were brought into the communal lounges and left to watch television with very little interaction and stimulation. Carers were not responsive to people's mental and emotional well-being.

Not all care plans contained a life history booklet about the person which gave detailed background information about the person, their likes and dislikes and information about their interests.

A complaints policy was available and procedures on how to complain were displayed around the home. The service had records of all complaints that had been received which logged details of the complaint and the actions taken to resolve the complaint.

Is the service well-led?

Requires Improvement

The service was not always well led. Quality assurance audits were completed in areas such as medicine management, infection control, housekeeping and care plans. However, some

of these audits were ineffective and did not pick up the issues we found during this inspection such as the issues around the cleanliness and condition of the home.

The service did not promote a positive culture within the home. Senior managers was not aware of the negative culture and poor care that we observed within the service throughout the inspection.

Staff meetings were taking place on a regular basis. Minutes of the meeting were displayed in the staff room so that care staff who could not attend were able to read what had been discussed.

Murrayfield Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 on 18 and 19 October 2016 and was unannounced.

The inspection team consisted of three inspectors, a specialist nurse advisor and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we visited the home we checked the information that we held about the service and the providers including notifications and significant incidents affecting the safety and well-being of people who used the service and safeguarding information received by us. We reviewed the Provider Information Return (PIR) which the provider had sent to us. A PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also looked at action plans that the provider had send to us following the previous inspection in September 2015.

We contacted the local commissioning team, the local health watch and a number of health and social care professions in order to obtain their feedback about the home and the service that it provides to people.

During the inspection we observed how staff interacted and supported people who used the service. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing.

During the two days inspection we spoke with 33 people, eight relatives, the deputy manager, two area managers, one healthcare professional, one visiting GP, six unit managers (nurses), one activity co-

ordinator, four senior health care staff, six care staff and the cook. We reviewed 20 care plans, nine staff files, training records and records relating to the management of the service such as audits, resident, relative and staff meeting minutes and a number of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us that they generally felt safe living at Murrayfield Care Home and felt safe when supported by the care staff. One person told us, "Yes, I feel safe, it's okay here." Another person stated, "Yes, it's quite safe here." However, one person commented, "One day I asked the nurse to help me get into bed to have a rest, she didn't answer me, just ignored me. It only happened once." Relatives were also confident that their relative was safe at the home. One relative stated, "I feel [relative] is safe. They never let her do anything on her own. They never leave her in her room on her own." Another relative explained, "I know she is in good hands and safe. I even take holidays now, before I never would." However, despite this positive feedback there were some aspects of the service that were not safe.

A safeguarding policy was available at the service which gave information about the different types of abuse and staff member's roles and responsibilities when identifying and reporting suspected abuse. Safeguarding adults posters were displayed around the home listing professionals who could be contacted if abuse was suspected. This included the local authority and the Care Quality Commission (CQC). The policy also outlined the providers responsibilities in relation to the delivery of training and how the provider was to assure themselves that the training knowledge had been embedded and that care staff clearly understood what safeguarding was and the actions to take if abuse was suspected. The policy stated, "The understanding and compliance of safeguarding issues will also be monitored on an individual and group basis under the supervisions process."

We spoke to a variety of staff members including unit managers, senior care staff and care staff about their understanding of safeguarding. We found that the unit managers and senior care staff demonstrated a good understanding of safeguarding and knew the actions to take if abuse was suspected. However, care staff did not demonstrate any understanding of what safeguarding was. Care staff could not describe the various types of abuse and until the inspectors further prompted what it meant, where they were then able to tell us the actions that they would take if abuse was suspected. One carer told us, "Still waiting for a training. I heard about it, I don't know how to describe it." Another carer explained, "Making the environment and people safe, depends on the tables and make sure they are alright in bed." When prompted, the second carer, listed verbal abuse and stated that she would report any concerns to her line manager. A third carer explained what they thought safeguarding was and told us, "If we received a complaint from a resident or family member." Again the third carer had to be prompted about safeguarding and that it was not always linked to complaints before she could explain the actions that she would take. A fourth carer had limited understanding and tried to explain safeguarding as, "Something to do with the police. If I hit the resident they can raise a safeguarding against me or if they hit me I can raise a safeguarding against them.

Most care staff that we spoke to could not explain to us what was meant by the term 'whistleblowing'.

Risks associated with people's care and support needs were assessed and provided clear information and guidance to all care staff on how to support people appropriately in order to reduce or mitigate any risk identified. Examples of risk assessments that formed part of the care plan included falls, moving and handling, bed rails, use of call bells and choking. Individual risks associated with people's care and support

needs were also identified and assessed. Examples included risk of pressure sores, urinary tract infections and behaviours that may challenge. Risk assessments were reviewed every six months or more frequently if required and were updated when there was a change in a person's condition.

Where people were assessed as being at high risk of dehydration and the person's fluid intake needed to be monitored, recording was inconsistent. Fluid charts did not give information on how much a person should be drinking per day and charts were not totalled at the end of each day. This meant that people's fluid intake could not be monitored as there would be no record of how much fluid a person had consumed. If a person had a low intake over consecutive days, there was a risk that the records would not indicate that action might be needed to avoid the risks associated with poor fluid intake such as recurrent urinary tract infections, poor skin integrity or weight loss.

We looked at two people's fluid intake charts. Both had inconsistent recording where certain days it was noted that there was no recording and on other days recording ended at around 17.00 and there was no further recording of any fluid intake during the evening or night. Where low fluid intake was recorded, there was no record of what actions had been taken.

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

Poor standards of cleanliness were observed in various areas of the home. The service had a housekeeping team in place where cleaning schedules were followed. However, these were seen to be ineffective as specific areas were observed to be extremely dirty. On the first floor, the dining area was seen to be dirty especially around the corners of the walls, the floors and the walls and where the food service hatch was located. When we entered the kitchen area on the first floor, where tea, coffee and meals were reheated, we found the microwave to be dirty, drawers and cupboards had spillages that had not been cleaned. There was also food and drink stains on the wall which had not been cleaned.

We walked around the home and looked at the bathrooms, toilets and shower rooms on each level of the home. We found that most of these areas were used as storage areas where wheelchairs, hoists and walking frames were kept. In one shower room on the first floor we found two bottles containing chemicals, one of which had no lid and was open. We also found a prescribed medicated cream for one person. In another shower room, on the same floor, we found a bottle of mouthwash which had been left. All these items were in easy reach to people especially those living with dementia who may not have understood what they were and mistaken them as something to drink or eat.

During our observations on the first day of the inspection we noted a spillage on the floor in the ground floor lounge. This was highlighted to the nurse in charge. However, when we returned on the second day of the inspection we found that the spillage had still not been cleaned. Observations noted by the two experts by experience also included details of poor infection control, poor cleaning standards and overall that the home was in a poor state of repair. For example, we observed one care staff, after supporting a person with their personal care, dispose of the dirty water that was used in the bathroom sink. The water contained faecal matter. On the sink there were the person's personal items such as their toothbrush, tooth paste and dentures.

Sluice rooms located around the home were unlocked even though a sign was situated on the doors stating that the sluice room must be locked at all times. A sluice room is where used disposables items such as incontinence pads and bed pans are dealt with, and reusable products are cleaned and disinfected. This meant that people living at the home could access the room at any time and this was a potential cross

infection risk. People entering the sluice room might also be able to have access to chemicals or equipment that may cause harm.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection, we walked round the home and showed the issues we had found to the deputy manager. The deputy manager then showed the area manager and as a result, on the second day of the inspection we observed that the provider had begun to take remedial action to deal with the issues that had been highlighted. This included replacing microwaves, deep cleaning, re-decorating the dining room and replacing the kitchen on the first floor.

People were supported with their medicines safely. At the focused inspection that we carried out in December 2015, we looked at the improvements the service had made after we had taken enforcement action in relation to unsafe medicine management systems and processes. The service was found to have made significant improvements and was no longer in breach of the regulations. During this inspection, we found that the service had sustained these improvements. People received their medicines as prescribed. Medicine storage areas were noted to be clean and secure. Sufficient stock levels of medicines required within the home were held securely and where medicines needed to be disposed of, there were procedures in place to ensure this was done safely and appropriately.

Unit managers were able to explain the process used for ordering people's monthly medicines to ensure that these were received on time and making sure people had their medicines when they needed them. We looked at a sample of Medicine Administration Records (MAR) for 24 people who used the service. There were appropriate arrangements in place for recording the administration of medicines. These records were clear and fully completed. Records showed people were receiving their medicines when they needed them, there were no gaps on the MAR's and any reasons for not giving people their medicines were recorded.

Controlled drugs were stored and managed appropriately. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971.
A number of people received medicines which were disguised in food or crushed. When medicines were being administered covertly to people we saw there were the appropriate agreements in place which had been signed by the GP, family and pharmacist.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, there were in place. These were tailored to the individual and provided staff with guidance on when these medicines should be administered. Records showed that all qualified staff had completed medicines management training and that medicines competency assessments had been completed for those staff who administered medicines.

Each person had a personal emergency evacuation plan in place which detailed their room number, their next of kin details, a mobility coding which outlined their level of mobility and a list of their medical conditions. This was available in a central file held as part of the emergency grab bag which would be used by professionals in the event of an emergency.

All accidents and incidents were recorded on an electronic system. We looked at accidents and incidents that had been recorded for September 2016. Each record contained details of the person, details of the incident or accident that had taken place, the actions taken, any investigative action taken and any lessons that were learnt. An overview was held centrally by the registered manager who held responsibility in

overseeing each entry that was made and ensuring that appropriate actions were taken. Monthly reports were also sent to community and health access team (CHAT) who supported the home with the health and clinical needs of the people living at the home. The CHAT is an initiative which supports nursing and residential homes in the London Borough of Enfield so as to reduce and prevent hospital admissions and enable services to support people with their health and medical needs within the home.

A needs assessment was completed for each person on admission to the home. This assessment looked at the level support a person required in areas such as personal care, continence care, moving and handling, skin care and communication needs. These needs assessments were then used to ascertain the level staffing support required on each of the floors within the home. Throughout the two days of the inspection we observed there to be sufficient staff visible around the home. Care staff did not seem to be rushed and were seen to complete tasks in a timely manner. We asked people about whether they thought there was enough care staff available to meet people's needs. One person told us, "Yes, there are enough staff." Another person stated, "Enough? There are too many!" A third person made the comment, "There could be more staff sometimes, especially overnight."

We looked at the home's recruitment process to see if the required checks had been carried out before staff started working at the home. We found that there were safe processes in place whereby criminal record checks had been undertaken, written references and proof of identity had been obtained for each staff member employed. The provider also used a computer system which was linked to the police and the immigration department and checked the legality of documents that were submitted by potential employees as part of their identity verification.

There was a record of essential maintenance carried out. These included safety inspections of all portable appliances, gas boilers and electrical installations. The fire alarm was tested weekly to ensure it was in working condition and there was a record of fire drills. There was a contract for maintenance of fire safety equipment. The home also had a fire risk assessment in place.

Requires Improvement

Is the service effective?

Our findings

We received mixed feedback from people and relatives about the quality of care that they received and whether they felt care staff were knowledgeable and adequately skilled. One person told us, "Staff are really good. They really look after us." Another person stated, "I think they are brilliant. They are very friendly. I'm allowed to go out and smoke here." A third person commented, "It gets lonely, nice staff, but they are too busy to talk." Relatives comments included, "The staff are very co-operative and nice." However, despite this positive feedback there were many aspects of the service that were not effective.

At the last inspection in September 2015, we found the provider in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We did not see documentation showing that all staff were supported to fulfil their roles and responsibilities through regular supervisions and appraisals. During this inspection, care staff told us that they felt adequately supported and received regular supervision. One nurse told us, "The last supervision was done one or two months ago with the unit manager." Another care staff confirmed, "I feel supported and receive regular supervision." However, one unit manager did make the comment that, "I have not had any supervision in the 15 months I have been here."

All newly appointed care staff were required to attend a two-day induction programme which covered areas such as orientation to the home, health and safety, residents and policies procedures. Care staff were then required to attend training in mandatory topics such as safeguarding, moving and handling, basic life support, fire awareness and health and safety.

Records confirmed that all staff received training in the mandatory topics as well as additional topics such as dementia care, first aid awareness, MCA 2005, food hygiene and infection control. Care staff also confirmed that they received regular training. One care staff told us, "I attended induction for three days and then trained with a senior." A senior carer told us, "Lots of training, dementia, pressure sores and moving and handling."

All care staff, on completion of the course they attended, were awarded a certificate confirming their attendance. However, records of their completion of induction and copies of any certificates were not kept as part of the care staff file. A training overview was held by the service which listed each care staff member, the training completed and the date it was due to be refreshed.

The provider provided training online as well as practical sessions linked to the on line training. Care staff had access to computers to enable them to complete training sessions as and when required. However, when speaking to care staff we noted that they had limited understanding and awareness in certain topic areas.

For example, some care staff demonstrated very little understanding of the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). When we asked care staff about the MCA their responses included, "They got their own minds, everybody on this floor," "Depends on everybody, some

people have capacity and we have to assist them" and "If they can't take decision, don't have consent." Two care staff had no knowledge of the MCA and all care staff that we spoke with did not know what a DoLS was. We also found that care staff had limited understanding and awareness of what safeguarding and whistleblowing was which we have reported on in detail under the 'Safe' section.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. During this inspection, we found that the service was meeting the requirements of the MCA 2005 and the Deprivation of Liberty Safeguards. Where any person living at the home lacked capacity, we saw evidence that a mental capacity assessment had been completed and a Deprivation of Liberty Safeguard authorisation had been made to the local authority. Where authorisations had been granted, this was documented within the care plan including details of any conditions that had been set. The registered manager held an overview of each person who had been granted an authorisation and the date it was due to expire so that re-authorisation could be requested.

Records showed that where a person lacked capacity to make a specific decision, a multi-disciplinary approach had been taken in order to reach a decision which was in the person's best interest. Where risk assessments were in place in relation to the requirement of bed rails, we saw that a best interest decision had been made on behalf of the person, especially where they lacked capacity, and that the decision had been discussed with the relatives. Where a decision to administer covert medicines had been made we saw evidence that the family, GP and pharmacist had been involved in the decision making process. This had been appropriately recorded within the persons care plan. We also saw records of best interest decisions that had been made in relation to a person requiring bed rails or a hospital bed.

Care staff understood the need for obtaining consent from the person that they supported. One carer told us, "I always knock on the door. I explain to them even if they have no capacity." However, care plans did not evidence that consent to care and support had been obtained from the person or where the person was unable to consent, that a relative or advocate had consented on their behalf. We told the deputy manager and area manager about this who stated that a consent form was available within the care plan and that they should be signed. We informed them that out of the 20 care plans that had been looked at, none of them had been signed. We did see signed consent forms asking for permission from the person to have their photos taken and where specific equipment was required such as bed rails, people and relatives had signed consenting to this decision. The area manager confirmed that this issue would be addressed immediately.

During the two days of our inspection we observed poor practices in relation to people's mealtime experiences as well as the way in which people were supported to remain hydrated and maintain a healthy and balanced diet.

On the first day of the inspection we arrived at the home at approximately 08:05am. We proceeded to walk around the home and observed at 08:40am that six people were sat in the dining room on the first floor. No care staff were observed to be in attendance and people did not have any visible drinks available to them. We re-visited the lounge at 09:10am and 09:15am and found that this situation had not changed and people still remained seated in the dining room with no breakfast and no visible drinks. Breakfast was first served at 09:50am. This meant that people were brought into the dining room at or earlier than 08:40am and were not served breakfast or any drinks for over an hour at least.

On the second day of the inspection, we arrived at the home at 07:40am. We found that four people were sat in the first floor dining room, one of whom was the same person seen the day before. No care staff were in attendance and no drinks or breakfast were visible. At 08:55am we went back to the dining room and found a further three people were sat waiting for their breakfast. We observed that some people had already been sat in the dining room for over one hour without any drinks or breakfast. People were then served breakfast at 09:00am.

One person did not receive their breakfast until 9.50am as they required support with their meal and therefore was left until the end to be supported after everyone else had finished. This person had been observed sitting in the dining room at 7:40am, which meant that they had been sitting unattended and without a visible drink for a minimum of two hours before they received their breakfast. This person repeatedly requested a hot drink. They kept stating, "I have had no drink or nothing." We observed that the person was not being given the drink that they had requested. We asked the care staff as to why a drink had not been given to the person who was making the request. The response from the care staff was, "We have no beakers, they haven't come up from the kitchen." After we questioned the care staff, they went and got a beaker from the kitchen and gave the person the drink they had requested.

We also observed breakfast on the second floor on the second day of the inspection. Six people were seen to be seated in the dining room and were eating sandwiches with a drink. We asked a care staff why people were offered sandwiches and whether this was their breakfast. The care staff responded by stating that because some people took medicines early in the morning they were offered a sandwich and a drink at the same time. Breakfast again was served at around 09:35am but we noted people had been sat in the dining room since 07:50am. One person was observed saying aloud, "I haven't moved! You put me here and leave me here for four hours!" As he was saying this, a carer walked past and did not address his comment, engage with him or provide reassurances. Another person told us, "The staff work very hard. You get up for breakfast, wash, clean teeth. You seem to sit in the dining room for ages. I was used to getting up and having a cup of tea."

We observed that when people were offered cereal or porridge for breakfast, sugar was added to what they chose but not mixed in. This meant that where people were unable to mix the sugar into the porridge they would be eating the sugar first and the unsweetened cereal or porridge afterwards. Food was not presented in an appropriate way for people.

During our observations on both days we noted that the meals looked appetising and people seemed to enjoy the meal that they were offered. However, people and relatives provided us with mixed reviews about the food and the choices available. People's negative comments included, "The food isn't good. My wife has to bring in my meals every day" and "The food is never nice." Positive comments included, "Yes, the food is good" and "The food is good considering they are trying their best." Relatives comments included, "I think people would be happier with better quality food" and "The food is really good. Makes my mouth water to be honest."

Based on the mixed feedback on the first day of the inspection, two inspectors requested to eat lunch with people on the second day of the inspection in order to taste some of the food that was prepared and served to people living at the home. The food had been prepared and presented appropriately and no concerns were noted with the taste of the food.

We saw that some people were offered a choice of what they wanted to eat but this did not happen consistently. People told us that they were not offered choice and had to eat what was given to them. One person told us, "No choice, what they do is what you get." Another person stated, "There is no choice." A third person said, "You just eat what they give you." During the second day of the inspection, we observed a carer preparing a plate of food to be taken to a person who needed support in their room. The carer had not asked the person what they wanted to eat and had decided for them what they were to be given. Another carer then pointed out that the person may prefer the alternative option. Whilst the first carer was thinking about what to do we pointed out to the carer that maybe they should ask the person what they would like rather than deciding for them. The carer responded by going and asking the person what they would like to eat.

On both days of the inspection we saw that people were not offered an alternative meal as care staff were not aware that an alternative option was available and had been prepared and kept in the hot trolley ready to be served. On the first day of the inspection, the vegetarian option, from the ground floor, was returned back to the kitchen untouched. On the second day, the chef had to tell care staff that there was an alternative meal available kept in the hot trolley which they then removed and offered to people.

Our inspection in September 2015, found that people did not get a choice if on a pureed diet. We discussed this with the manager and she acknowledged that this needed to be addressed. The manager also explained that the home had recently introduced pictures of foods that were on the menu so that people could pick what they would like to eat with the help of pictures and they were starting to use this on the second floor of the home. However, during this inspection we found that people did not get offered a choice in relation to pureed foods and when the meal was presented to people these did not look appetising. Although the service had previously confirmed that pictorial menus were being used, we found that this was not the case. The deputy manager confirmed that pictorial menus were not being used in the home as a method of offering choice to people.

On the first day of the inspection, a menu for the day was on display in the reception. However, this did not match the food that was actually served on the day. We highlighted this to the deputy manager and area manager who informed us that the menus in the reception required updating.

Menus were planned by the lead chef at the home. We were told that senior managers held meetings with the lead chef to discuss the list of food preferences obtained from people, which was used to set the menus. People's likes, dislikes and preferences in relation to food were available within their care plan. Care plans also documented where people had specific cultural or religious requirements. The chef and other kitchen staff were able to confirm this and also held records of people's religious, cultural or medical dietary requirements. However, we did not see any evidence to confirm the process in which the menus was set by senior managers and the lead chef.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A variety of drinks was available throughout the day and people had access to snacks and biscuits when requested. People confirmed that drinks and snacks were available. One person told us, "Yes, tea and cake. I

can get a cup of tea whenever I want." Another person told us, "Yes tea and biscuits every day and for visitors."

People's weights were checked and monitored on a monthly basis. Where weight loss or excessive weight gain was noted, charts were completed to monitor food intake as well as appropriate referrals made to help ensure that people's nutritional needs were met. Where people required professional input in relation to dietetic services or the speech and language therapists, we saw records of referrals that had been made. Records and guidance were available where people had been assessed to require specialist assistance with their meals such as a pureed diet or thickening agents to be added to their meal or fluids.

Records showed that people were seen by other healthcare professionals, including speech and language therapists, physiotherapists and dieticians, podiatrists and chiropodists when required. One visiting GP who we spoke with told us they had seen a lot of improvements over the last two years. The GP confirmed the staff were able to manage issues and attended to urgent needs before the arrival of the doctor. One healthcare professional told us, "The unit leads are all great, skilled and recognise changes and report to our service, GP or 999 if serious."

Requires Improvement

Is the service caring?

Our findings

Most people and relatives told us that they found care staff caring and felt well cared for at the home. One person told us, "They are really nice to us here." Another person commented, "I can't complain. The girls [care staff] are nice. Everybody is very good to me and good to my visitors." A third person told us, "Staff are very kind. They would do anything for me." Relatives comments included, "They are always cleaning her room, very kind to both of us" and "My relative arrived here unexpected after a fall and it was just perfect." We also received some negative comments from people which included, "I don't like it, they treat us like children" and "They are not individuals interested in the person."

However, despite the broadly positive feedback we received from people and relatives, our observations throughout the two days of the inspection were not always positive. We observed very little interaction between people and care staff. We saw people were ignored, particularly when they made a request or were calling for attention. Care and support provided to people was not person centred but was more focused on the tasks that needed to be completed. We saw a number of occasions where care staff and other staff members such as the chef would walk in and out of a room where people were without even greeting or acknowledging them. On one occasion, in the second floor dining room, we saw the cook bring up the food trolley and knock into one person in a wheelchair. The cook made no effort to address the person or apologise for knocking into them.

We witnessed poor care staff attitudes with little care and consideration for people that required support, their choices and wishes. Where people were being supported with personal care, we observed some staff who were respectful of people's privacy and dignity and interacted with them whilst supporting them, whereas others were seen not greeting or speaking to people or explaining what they were doing whilst supporting them.

During the inspection, we observed how staff interacted and supported people. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing.

During the SOFI we saw that people were generally left unattended and were either passively watching television or dozing off to sleep. Care staff did not interact with people unless they requested attention. One person was observed to request a drink which was provided, but drinks were not offered to anyone else in the same room. After the SOFI had been completed, when we returned to the lounge about one hour later we observed the same people sitting in the same positions as they had been noted to be in during the SOFI.

During lunchtime, we observed that the two people who had been part of the SOFI observation had been given their lunch. This had been left in front of them. At 13:50 we saw that the two people had not eaten and the plates were still full. There was very little staff interaction or encouragement with both these people during the SOFI and at lunchtime especially to eat some of their meal. These two people were also returned

to the lounge after their lunch and left sitting in front of the television for the remainder of the afternoon.

On the second day of the inspection, we saw the same person who had been left until last for breakfast, had been left until last for their lunch. This person, between 13:00 and 14:00, continually asked for a drink but was ignored by all care staff who were in the lounge. At 14:00, a carer went up to the person and told them that they were going to get them lunch. The person asked the care staff what the time was. Instead of telling them the correct time they proceeded to tell them it was only 13:00. We asked the care staff why this person was left until last to be given their lunch and also pointed out that this was what had happened in the morning. The care staff responded by saying, "No reason, it's just that [name of person] needs support with their meal and we are busy with everyone else before we can help them."

One person had been given a tray of food, in their own room, by a carer who then left the person on their own to eat independently. We saw that the person was sat in a chair, trying to balance their tray of lunch on one hand whilst trying to cut the food with their other hand. A table had not been provided and the care staff had not offered to help cut the food. We intervened and gave the person a table so that they could eat their meal properly.

We saw one example of where a carer was seen to be mocking a person. They pretended to be approaching the person as if they were an aeroplane then pretended to flick or grab the person's nose and then walked off laughing. We reported this to the deputy and area manager for them to address.

During the two days we consistently saw that people were taken to the lounge and were left to watch the television with very little or no interaction between them and the care staff. We saw that people were not offered a choice of what they would like to watch. On the first floor the television channel was not changed at any point throughout the day. Care staff did not appear to be busy and were seen sat in the same room with no interaction with people. Care staff did not try and organise and deliver any type of activity.

Care staff did not put person centred care into practice or provided effective care that met the needs of people living with dementia, even though specific dementia awareness training had been delivered recently within the home. When we asked care staff about what they thought person centred care meant, they were unable to explain this to us. Most care staff told us that they had not heard of the phrase person centred care but when we explained and asked further questions they were able to explain the meaning.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the two days of the inspection we did observe some positive interactions between people and care staff. There were examples of where care staff spoke with people to check if they were comfortable and if they needed their chair to be pushed nearer to the table. Another example was a conversation between the person and care staff about an old war movie that the person had been watching.

People told us that they were treated with dignity and respect. One person told us, "Staff are very kind. They would do anything for me." Another person told us, "Some are better than others." Care staff understood how to protect people's privacy and dignity. During our observations, we saw one carer ensure that privacy and dignity was maintained for the person that they were supporting. They made sure that the door was closed and drew the curtains of the person's room. The care staff covered the person whilst supporting with personal care. One care staff explained that maintaining people's privacy and dignity included closing the person's bedroom door as well as covering people's body when exposed. Another care staff told us, "We

make sure the curtains are closed. Some residents don't want a male carer. Some don't mind."

Care plans documented that advanced care planning and end of life care was discussed with people and their relatives. People's choices and wishes were recorded in relation to planning the way in which they wanted to be cared. One healthcare professional commented, "There have been some excellent examples on all floors of excellent end of life care."

Requires Improvement

Is the service responsive?

Our findings

People's feedback about the activities that were organised within the home were negative. When asked if people thought whether there were enough activities happening within the home, people's responses included, "There are no activities, just bingo once a week," "What activities? There is nothing" and "Not much. They do bingo or something like that. Most people don't do nothing."

The home had an activity board which listed activities that were scheduled to take place during the week. On both days of the inspection activities such as in-house shop, arts, craft, word search and puzzles, baking cupcakes and a visit from the hairdresser had been scheduled to take place. However, most of the activities listed did not take place apart from people visiting the hairdresser and bingo, which had been scheduled for the next day.

The provider had employed two activity co-ordinators who were responsible for organising a variety of activities within the home. One of the activity co-ordinators told us that the main events that they organised included bingo, tea parties and if the weather was good they would go into the garden and do some gardening or planting. The activity co-ordinator also confirmed that they did very little in terms of going out on day trips.

During the two days of our inspection we saw very little interaction, activity or stimulation that was initiated by care staff that were on duty. People were always seen to be taken to the lounge and positioned to watch television throughout the day. Care staff did not appear to be caring and responsive to people's mental and emotional well-being.

We asked care staff about the activities that took place within the home and whether they as care staff were responsible for organising or delivering any activities if and when the activity co-ordinators were not around. One care staff told us, "To be honest we are carers. Our job is trained to be a carer. We have nothing to do with activities. The company gets people. We see the board." A nurse stated, "Sometimes there is bingo. I think people are bored. I try to encourage one to one sometimes after lunch." A second care staff stated, "We have an activities lady." A third care staff said, "Not enough activities. If you call watching TV an activity. A lot of people don't want to do activities."

We observed care staff ignoring people especially when people showed interest in being occupied with an activity. We saw one person pick up a box of puzzles which they seemed to be interested in completing. A care staff member saw that the person had picked up the box of puzzles but made no attempt to go to the person and encourage or support them to sit down with a view to completing the puzzle together. The care staff ignored the situation and the person eventually put the box down without giving it a go.

On the second day of the inspection, we saw that one care staff brought out a box of colouring pencils with colouring paper for people to be involved in an activity. People began to take the paper and pencils and started to colour. However, most of the pencils were blunt or were in a poor condition and some of the colouring pages that were handed out had already been used. One person who was sat at the table where

the colouring was taking place stated, "I ain't doing that. I'm not ten years old. We used to colour when we were at school."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans did not always have a life history booklet completed about the person and information about the person had not been reflected within the care plan. For example, where the service had applied for a DoLS authorisation and where this had been granted with conditions, this had not been reflected within the person's care plan. The care plan that the service used contained a section where information was to be gathered on the person and was named 'My Life, My Choices'. Not all of the care plans that we looked had this document completed. However, where this document was completed for people, it was noted to be person centred and listed people's likes and dislikes as well as their choices and preferences. We highlighted this to the deputy and area manager who told us that they would look into these inconsistencies.

Unit leads, senior care staff and some care staff knew the people that they supported. They demonstrated knowledge and awareness of people's likes and dislikes and how they wish to be cared for.

People and relatives confirmed that they felt involved in the care planning process and were listened to. One person told us, "They listen but they can't always do what you ask because there are too many people to care for." Another person stated, "They do listen and fix things quickly, they are very busy though." One relative told us, "Yes, I feel totally involved. Any issues I have they get back to me really quick." Another relative said, "They always phone and inform me if anything is wrong and we are always told about annual meetings.

We saw evidence that care plans were reviewed on a monthly basis or as and when required if significant changes were noted. Staff responded promptly when people's needs had changed. We saw records of where care staff had observed changes for one person who had begun coughing especially when eating or drinking. This had been promptly referred to the Speech and Language Therapists (SALT) and a diagnosis had been made based on assessment. The care plan had been updated to reflect the SALT instructions.

We observed staff handover on the second day of the inspection, between the night staff and day staff. The team of nurses and care staff walked to each person's room where a brief handover was given about the person, any significant changes and areas of concern to be monitored. Handover records were also kept and contained a brief summary of the person and any significant information about the person that care staff were to be aware of.

The home had a complaints policy in place and there were procedures for receiving, handling and responding to comments and complaints. We saw the policy also made reference to contacting the CQC and local authority if people felt their complaints had not been handled appropriately by the home. Information about how to make a complaint was on display in the home and the majority of people and relatives we spoke with told us that they felt able to complain if they needed to. One person told us, "I would go to [the name of registered manager] with any problem."

We looked at the most recent complaints that the home had received. We noted that these had been responded to promptly and details of the actions taken and lessons learnt had been recorded. The service also had a complaints overview which enabled senior managers to monitor complaints that were received and make note of any trends or patterns.

We saw that meetings were held for people living at the home as well as relatives where they could give their views on how the home was run. Topics of discussions included staffing levels, recruitment of care staff, activities and laundry issues.

Requires Improvement

Is the service well-led?

Our findings

During the inspection in September 2015, records showed that the service carried out medicine's audits. We found that these were not comprehensive and failed to pick up the serious issues that we had identified. We also noted that there was a lack of audits for other aspects of the care in the home. For example, there was no evidence of audits in respect of infection control, staff files and housekeeping.

During this inspection, we found that some improvements had been made around medicines management and a number of quality audit systems had been introduced. However, some of these were not always effective or robust enough to identify problems within the service. The quality audits that had been introduced such as the housekeeping audit, did not highlight the issues that we found as part of this inspection. For example, a housekeeping audit had been completed in September 2016 and had not identified any of the issues that we had highlighted in relation to the cleanliness of the home. A health and safety audit completed on 6 October 2016 identified that, "The bathrooms that are remaining need to be refurbished so as not to cause possible infection control issues." However, there was no action plan available as to when this work was due to be completed.

We saw care staff meeting minutes from 28 July 2016, that had highlighted to care staff issues such as, "Chemicals left around corridors and bathrooms inappropriately," "Not much daily activities happening" and "My choices and life story not be filled up for new residents." This meant that these issues had been identified in July 2016 but no action had been taken by the management team to address these issues until they were highlighted again as part of this inspection.

The service did not promote a positive culture within the home. The registered manager and other senior managers were not aware of the negative culture and generally poor care and interactions that we observed within the service throughout the inspection until this was pointed out to them.

The provider had submitted an action plan, in response to the last inspection in September 2015. This listed a number of improvements that the home had planned to make which included addressing the lack of meaningful activities, improving the dining experience for people and the lack of supervisions and appraisals. However, none of these improvements had been implemented. In addition, the management did not have oversight of how people were supported and cared for within the home.

For example, part of the action plan stated that monthly dining room audits would be completed on each floor. During this inspection, we found that these had not been completed. This was confirmed by the deputy manager. Therefore, the management team were not aware of people's mealtime experiences until this was highlighted to them as part of the inspection.

The provider did not have any systems in place which gave them the assurance that care staff understood the training that they had received especially in key topic areas such as safeguarding, MCA 2005 and DoLS.

Staff told us that they received regular supervision and felt supported in their role. An overview was available

which listed when staff had received their supervision. This was held by the registered manager. However, we were unable to view any of the supervision and appraisal records for staff to confirm this. Staff files contained some supervision records dating back to December 2015 but we were unable to view any recent records. We informed the deputy manager about this who explained that supervision records were held by the registered manager, but as she was unavailable during the two days of the inspection there was no way in which these records could be obtained.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence of audits that had taken place which looked at the safe management of medicines, care plans and staff files. Where the registered manager had completed these audits there was also a record of the issues that they had found and the actions taken to resolve the issues highlighted.

The service had systems in place to monitor quality through surveys that people, relatives and visiting professionals could complete. This was an electronic quality survey. The deputy manager explained that they asked people, relatives and visiting professionals who visited the home to complete a questionnaire on the home's iPad and they did this so that feedback could be obtained on an on-going basis. This information was then recorded on the home's system and any necessary action required was taken to rectify any issues. Feedback received from people, relatives and visiting professionals was overall positive.

All staff members also had the opportunity to complete a staff survey, through the iPad, which asked staff to respond to questions such as, "I feel part of a team?" and "I have the knowledge and tools I need to do a good job." Staff were able to complete these questionnaires anonymously. Results of completed questionnaires seen were positive between the period of July 2016 and October 2016.

Most people and relatives we spoke with knew who the manager was. One person, when asked if they knew the manager responded, "[Name of registered manager]. She is off at the moment. Don't know who the replacement is." Another person said, "Haven't seen the manager recently. She often comes round. Once I told her I liked crispy rolls, so next time she brought me some." One relative said, "The management are very amenable. If I want to speak to them they are very amenable." Care staff were also positive about the registered manager and the overall management of the home. One member of staff told us, "They are trying their best." Another said, "All are approachable." All staff we spoke with told us that they felt able to approach the management team if they had any concerns. However, one week after the inspection we learnt that the registered manager had left their position and that the home did not have a registered manager in place. The provider gave assurance that arrangements had been made to ensure that the home was appropriately managed.

Care staff confirmed that regular staff meetings were held to discuss areas of concerns, exchange of information and sharing of good practice. Care staff also told us that they discussed day-to-day issues during daily handovers. Records showed that the last staff meeting had been held in July 2016. Copies of the minutes were seen in the staff room, so that those care staff who were unable to attend had access to the minutes to read about what was discussed.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. However, on the first day of the inspection we did see people's confidential records had been left in a pile on the floor and above a filing cabinet, in the second floor lounge. Records were mainly communication and daily recording log books. We brought this to the attention of the deputy manager on the second day of the inspection who informed us that the documents

had been removed and stored appropriately.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not supported by care staff in a person centred way. Care was not delivered in a way which was appropriate, met people's needs and reflected their preferences. The provider did not ensure that appropriate activities were organised and provided to people which encouraged autonomy, independence and involvement within the community.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not supported by care staff with dignity and respect. Care staff did not put person centred care into practice or provide care that ensured people were treated with dignity and respect. Care staff did not interact with people unless they requested attention.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not protecting service users and was not doing all that is reasonably practicable to mitigate identified risks associated with people's care and support needs.

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 The provider failed to ensure that people were appropriately supported with their nutritional and hydration needs in order to maintain their health and well-being.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure that all areas of the home and equipment used by the service were clean, suitable for the purpose for which they were to be used and properly maintained.

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 Quality assurance audits that were being completed were not effective as they did not highlight concerns and issues around the home. Where issues were identified there were no action plans in place on how these issues were to be addressed and resolved. There was a lack of evidence that staff were supported to fulfil their roles and responsibilities through regular supervisions and appraisals.