St Margarets Residential Care Home

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 22 March 2017 and was unannounced. St Margarets Residential Care Home provides accommodation for up to 18 people, including people living with dementia care needs. There were 12 people living at the home when we visited. The home is based on two floors, connected by a stairway with a stair lift. Three bedrooms are shared double rooms and 12 bedrooms are for single occupancy.

The provider is registered as a partnership. However, following the death of one of the two partners, an application has been made to CQC to re-register the service as a new partnership. This process was still in progress at the time of this inspection.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At our previous inspection on 11 October 2016, we identified breaches of eight regulations. We issued warning notices requiring the provider to become compliant with regulations relating to consent to care and good governance by 10 January 2017. We also issued requirement notices requiring the provider to take action in relation to the registration of the service; person-centred care; safe care and treatment; staffing; openness and transparency; and the display of their performance rating.

At this inspection, we found some improvements had been made, but further improvement was required.

The provider had not met the requirements of the two warning notices we issued. They had not completed assessments of people's capacity to make decisions or recorded decisions they had made on behalf of people. However, they had provided additional training to enable staff to do this.

The provider had not put an effective system in place to assess, monitor and improve the quality of the service overall. However, some individual issues highlighted in our warning notice relating to good governance had been addressed; for example, fire safety checks had been completed and action had been taken to meet the needs of people with diabetes.

Two issues we identified at the last inspection, relating to the security of medicines and the care of a person with a catheter (a device used to drain a person's bladder through a flexible tube linked to an external bag) were only addressed during the inspection, after we raised them for a second time.

Individual risks to people were not always managed safely. Risk assessments had been completed for some, but not all the people who were potentially at risk of pressure injuries; and a person's risk assessments was not reviewed when they experienced multiple falls. However, environmental risks were managed

appropriately.

People told us they felt safe and staff knew how to identify, prevent and report incidents of abuse, although not all staff had attended refresher training in safeguarding, in accordance with the provider's policy.

Medicines were not always managed safely. Checks of the competency and understanding of staff who administered medicines had not been completed.

There was no clear induction process in place to ensure that new staff were sufficiently competent to work alone. Experienced staff had completed additional training, although their training workbooks had not been marked to confirm that they had understood the training.

Managers had started to conduct appraisals with some staff, but staff did not have access to regular sessions of supervision. While most staff said they felt supported by their managers, some staff felt communication could be improved to ensure information about people's well-being was shared effectively. They also felt the registered manager was not sufficiently visible around the home to provide the necessary guidance and direction.

People were satisfied with the quality of the food; although some people did not receive consistent support to make sure they ate and drank enough. Staff monitored people's weight and took action if there was unplanned weight loss.

Some staff did not actively listen to people or treat them with consideration. However, most people told us staff were kind and caring and we observed some positive interactions between people and staff.

Activities were limited to an hour a day and were not run consistently, although the home was involved in an initiative with a school and people enjoyed interacting with pupils who visited.

There were enough staff to meet people's essential care needs and recruitment processes helped ensure only suitable staff were employed.

Staff protected people's privacy and dignity, including when they provided personal care, and confidential information was kept secure. People were encouraged to remain as independent as possible.

People were encouraged to make as many choices as possible about their day-to-day lives. They were supported to access healthcare services when needed and were involved in planning the care they received. The registered manager sought and acted on feedback from people.

Staff were more positive about the service than at our last inspection. They had been given enhanced roles and responsibilities, which the registered manager assured us would be "meaningful".

We identified three breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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.

Assessments of the risk of people developing pressure injuries had not always been completed. When a person had experienced multiple falls, their risk assessment was not reviewed to consider any additional safety measures that could be taken. However, environmental risks were managed appropriately.

People's medicines were not always managed safely. Appropriate security arrangements were not in place for all medicines, although this was addressed during the course of the inspection. Staff had undertaken additional training in medicine administration, but checks of their competence had not been completed for most staff.

People felt safe at the home and staff understood their responsibilities to safeguard people from harm. However, some staff had not had refresher training in safeguarding in accordance with the provider's policy.

There were enough staff to meet people's essential needs and the process used to recruit staff was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Legislation designed to protect people's rights was not always followed and decision made on behalf of people were not documented.

Staff did not receive appropriate induction, training, supervision or appraisal to support them in their role. Although staff had received some additional training since the last inspection, assessments of their knowledge had not been completed.

People's dietary needs were met, although staff did not always provide consistent support to people to help ensure they ate and drank enough. Staff monitored people's weight and were clear about the action they would take if people experienced

unplanned weight loss.

People were supported to access healthcare services including doctors and specialist nurses.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always attentive to people and did not always treat them with consideration. However, most people told us staff were kind and caring.

Staff protected people's privacy and dignity at all times. They encouraged people to remain as independent as possible and involved people in planning the care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had not been reviewed since October 2016, placing people at risk of not receiving consistent care that met their needs. However, staff had a good understanding of people's needs and one person's care plan was updated during the inspection.

People enjoyed activities that were organised, including interactions with a visiting school group. However, activity provision was limited to an hour a day and was not provided consistently.

Staff provided examples of where they had responded promptly when people became unwell. People were supported and encouraged to make choices about aspect of their lives.

The provider sought and acted on feedback from people to help improve the service.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not met the requirements of two warning notices that we issued following the last inspection. Some issues raised in requirement notices following the last inspection were only met during the course of this inspection when we raised the concerns for a second time.

There were no effective systems in place to assess, monitor and improve the service or to ensure compliance with regulations relating to fundamental standards of quality and safety.

Staff had been given enhanced roles and responsibilities, although these had not yet taken effect.

St Margarets Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned 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 was also carried out to check whether improvements had been made from the October 2016 inspection.

This inspection took place on 14 and 22 March 2017 and was unannounced. It was conducted by one inspector and an expert by experience in dementia. 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 the inspection, we reviewed the information we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with five people living at the home, a family member, a doctor who had regular contact with the home and a visiting care worker from another company who supported a person on a one-to-one basis. We spoke with the registered manager, two 'managers' who were in day to day charge of the service, the head of care and four care staff. Following the inspection we received feedback from a social care practitioner from the local safeguarding and quality team.

We looked at the care plans and related records of care provided for five people. We also looked at staff training records, staff recruitment files, duty rosters, records of complaints, accident and incident records, and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the

experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At out last inspection, in October 2016, we identified breaches of regulations as fire safety systems were not operating effectively, medicines were not managed safely and there were not always enough staff to support people effectively. At this inspection we found some action had been taken but further improvement was required.

Individual risks to people were not always managed effectively. We identified people who were at increased risk of developing pressure injuries as they spent a lot of time sat in chairs, were incontinent or had poor nutritional intake. However, risk assessments had not been completed to determine their level of risk and measures that could be taken to reduce the risk. The registered manager told us of plans to start using a nationally recognised tool to assess people's pressure area risk. These were not yet in place, although two people had been given special pressure-relieving cushions and mattresses to reduce their individual risks. These were used when needed and the mattresses had been set to the correct setting for each person.

People's risk assessments were not reviewed when people experienced multiple falls. One person had experienced six falls over a period of five months and their risk assessment had not been reviewed during that time to consider additional measures that could be taken to keep them safe. We discussed this with the registered manager who agreed it was an area for improvement.

Although risk assessments were not always reviewed following falls, we saw staff did encourage people to use walking frames and sticks to help prevent falls when mobilising around the home. They had also sought advice from the GP of one person who had fallen and this had to a review of the person's medicines and checks to test for a urine infection.

Staff supported people to remain safe while minimising unnecessary restrictions. For example, staff encouraged people to mobilise on their own, whilst remaining close by, in case they needed additional support and allowed them to travel at their own pace. One person had been given a walking frame, but often preferred to use furniture for support while mobilising around the home. The person was aware of the risks involved, but chose to take them as they did not like using their frame.

Environmental risks to people were managed effectively. A series of fire safety checks were conducted on a daily, weekly and monthly basis. Where the checks identified deficiencies, these were addressed promptly. For example, a fire door did not close properly and was repaired; and a broken fire extinguisher seal was replaced. Staff had received additional training in fire safety since the last inspection and were aware of the action to take in the event of a fire.

Equipment was in place to enable staff to provide safe care for people, including special chair lifters that were fitted to dining room chairs. These allowed the chairs to be lifted slightly so people could be positioned close to the table without putting any stress on them or the staff member. Two people needed to use equipment to support them to transfer between chairs and their bed. Staff described how they always operated the equipment in pairs and in accordance with the manufacturer's guidance.

People's medicines were not always managed safely. Some medicines are subject to additional controls by law and require secure storage that meets a high specification. At the last inspection, we identified that the storage arrangements for these medicines did not comply with the enhanced security requirements, so could be vulnerable to misuse. On the first day of the inspection we saw this had not been addressed and the security arrangements were still not adequate; a cabinet that should have been secured to a solid wall was kept in the bottom of the medicines trolley. However, by the second day of the inspection, after we had reiterated our concerns, the cabinet was bolted to the wall and all medicines were stored safely.

Since the last inspection, most staff had completed additional training to administer medicines by completing a workbook produced by an external training company. The workbook required staff to complete a knowledge check, which was then marked by the training company to confirm they had the necessary knowledge to administer medicines safely. One of the managers told us the workbooks had been sent for marking, but had not been marked or returned. Therefore, the provider was unable to confirm that staff who were administering medicines had the necessary knowledge to do so safely. The provider had also introduced a process for staff to be observed administering medicines by a senior member of staff, to check they could do so competently. However, the senior staff member's medicines training was not up to date, so we could not be assured they had the necessary skills and knowledge to assess others. They had obtained a level two certificate in medicines administration seven years ago, but had not had their workbook marked or returned by the training company, which the registered manager said they were "chasing". The competency checks had only been completed for two staff members and not for the remaining staff who administered medicines on a daily basis. Therefore, the provider was unable to confirm that medicines were administered competently and safely by all staff. One of the managers told us, "We need to assess everyone's competence now and get the workbooks signed off." They said work to do this was in progress.

The registered manager had taken action to enhance staff members' understanding of medicines. Each staff member had been given a list of medicines to research and record their purpose, their alternative band names, their side effects and the symptoms of an overdose. The information was recorded in a book and kept in an accessible place for staff. This was a positive initiative to help improve staff knowledge of medicines.

Daily and weekly check sheets were in place to identify any gaps in people's MAR charts and we saw these had been used to prompt staff members to complete the MAR charts fully. There was also a suitable system in place to help ensure topical creams were not used beyond the manufacturer's recommended 'use by' date. Some hand-written entries on the MAR charts had not been checked by a second member of staff, as recommended by best practice guidance. A senior member of staff addressed this omission immediately.

Some people were prescribed medicines on an "as required" (PRN) basis. These included pain control medicines and sedatives. Detailed information was available for staff to know when, and in what circumstances, to give these medicines to people.

People said they felt safe at St Margarets. When asked if they felt safe, one person told us, "Definitely; they [staff] look after me." Staff were aware of their responsibilities to safeguard people from the risk of abuse. They knew how to identify, prevent and report abuse and said they would have no hesitation reporting concerns to a manager. One told us, "I would speak to the shift leader or manager; or I could blow the whistle to CQC or safeguarding." When staff found unexplained bruising to people, they completed body maps and investigated the causes. One person was experiencing bruising from the hoist sling, so a physiotherapist was contacted. They provided guidance to staff about how to positioning the sling in a way that protected the person from harm. New staff had completed safeguarding training as part of their induction. However, experienced staff had not received refresher training in safeguarding in accordance with

the provider's policy. One of the managers told us this was because the relevant workbook had been withdrawn by the training company and they were waiting for an updated version of it to arrive.

We received mixed views from people about the staffing levels. One person said, "They could do with more [staff]", but another person said, "Yes, there's enough [staff]; they're here all day". One of the managers told us that since the last inspection, the number of people being accommodated had reduced from 16 to 12. This had led to them reducing the staffing levels in the afternoon from three care staff to two care staff. During the inspection, we observed that staffing levels were sufficient to meet people's essential needs; however, staff told us it did not give them time to interact with people in a meaningful way. We discussed this with one of the managers who lived in a flat above the home; they told us they were always available to support people in the afternoons if required.

The process used to recruit staff was safe and helped ensure staff were suitable for their role. The registered manager carried out relevant checks to make sure staff were of good character with the relevant skills and experience needed to support people effectively. Staff confirmed this process was followed before they started working at the home.

Requires Improvement

Is the service effective?

Our findings

At out last inspection, in October 2016, we identified that staff did not always follow the Mental Capacity Act, 2005 (MCA) or its code of practice and this was a breach of regulation. We issued a warning notice requiring the provider to make improvements and become compliant with the regulation and ensure people's legal rights were protected. At this inspection we found the warning notice had not been met and the MCA was still not being followed.

The 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 MCA 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Information in people's care records indicated that most people living at the home had a cognitive impairment and were not able to make informed decisions about some aspects of their day to day lives. One of the managers confirmed this and said, "There are areas where everyone lacks capacity for some decisions." The manager showed us an MCA assessment they had conducted for one person; this followed the standard two-stage test, as recommended by the MCA code of practice. The assessment showed that the person lacked capacity to make informed decisions about an appropriate diet, the delivery of personal care and the administration of their medicines. Staff had clearly made these decisions on behalf of the person, as they were giving the person a diet they felt was suitable, they were delivering personal care in a way they felt was appropriate, and they were administering prescribed medicines to them. However, they had not documented these decisions in accordance with the MCA code of practice; therefore, they were not able to demonstrate why they were in the person's best interests.

Assessments of other people's capacity to make specific decisions relating to their care not been completed and other decisions staff had made on behalf of people had not been documented. There were no records to show that relevant people, including family members, had been consulted. Therefore, the provider was unable to confirm that care and support was provided with the consent of the relevant person or that staff were acting in people's best interests.

Some people's care plans included a 'consent to care' form. One person, who had capacity to make decisions, had signed this form to show their agreement with the care that was planned. The forms for two other people had been signed by family members, but staff had not checked that the family members had authority in law to act on behalf of their relatives.

Since the last inspection, staff, including senior staff, had attended a variety of training sessions about the MCA. One of the managers told us they had looked at a number of different forms to help them record mental capacity assessments and best interest decisions they had made for people. When we discussed the MCA with them, they showed an understanding of the requirements of the legislation. However, they had not applied that knowledge to the care planning process for the people they were supporting.

The continuing failure to ensure that care and support were only provided with the consent of the relevant person was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider had appropriate policies and procedures in place. DoLS authorisations were in place for two people and applications had been made for other people who met the relevant criteria. Staff understood the limit of the restrictions that were in place and knew how to keep people safe in the least restrictive way.

At our last inspection, we identified that staff did not always receive regular training to properly equip them for their role. At this inspection, we found some action had been taken, but the provider was still unable to demonstrate that staff were suitably skilled and competent for their role, placing people at risk of receiving unsafe or inappropriate care.

At the last inspection, the registered manager described induction arrangements for new staff as "a bit hit and miss". At this inspection, we found this was still the case; there was no clear process in place to make sure that all key topics were covered during the induction process; and there was no procedure in place to assess when staff were sufficiently competent to work alone.

Arrangements were in place for staff who did not have experience of care to complete training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The format used by the provider had two parts; a period of classroom-based training, followed by a period of working alongside experienced staff supporting people in the home. Once complete, a supervisor was required to conduct a practical assessment of the staff member by observing their practice and 'signing them off' as competent to work unsupervised. We found the practical assessments of two new staff members' practice had not been conducted, although they were already working without direct supervision.

Other, more experienced staff had completed a range of training since the last inspection, including food hygiene, health and safety, and infection control. The training required staff to complete workbooks, which were then sent to the training provider for marking. However, none of the workbooks had been marked, so the provider was not able to confirm that staff had gained the necessary knowledge or understanding from this training.

One of the managers told us that all staff had completed moving and re-positioning training in accordance with the provider's policy. However, a staff member who had worked at the home for several years, and frequently support people to move and re-position, told us they had not completed the practical part of this training. They said they had completed a workbook about the theory of moving and re-positioning and were hoping to cover the practical element during their Care Certificate training that was planned for shortly after the inspection. The lack of practical training in this essential subject put people at risk of harm as they may not have been supported to move in a safe and appropriate way.

The first language of an ancillary staff member was not English and we found they could only communicate in English using an online translation service. They had worked at the home for several years, but had not received training appropriate to their specific role due to their poor command of the English language. One

of the managers told us they were trying to find an interpreter to support the staff member to complete their training, but had not managed to achieve this yet. Therefore, we could not be assured that the staff member had the necessary knowledge to support them in their role.

At our last inspection, we identified that staff were not appropriately supported in their role through the use of supervision and appraisal. Managers had started to undertake appraisals of staff who had worked at the home for more than a year. These included a self-assessment by the staff member, followed by a discussion about their performance and any training or development needs. Appraisals had been completed for five of the 11 staff employed. The registered manager told us they were planning to introduce a programme of regular supervisions for staff, including staff who had worked at the home for less than a year. These would provide opportunities for managers to meet with staff, feedback on their performance, identify any concerns, offer support and identify training needs. However, this work had not started, so staff were still not being supported appropriately in their role to enable them to provide safe and appropriate care to people.

The registered manager told us they were also planning to introduce a system of direct observations of staff practice to check they were following people's care plans correctly. One of the managers told us they had started doing this, but there were no records of any of the observations they had conducted. The manager acknowledged that the lack of staff supervision was "a weakness" of the service.

The failure to ensure that staff received appropriate support, training, development, supervision and appraisal was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although most staff had not received supervision or appraisal, most told us they felt supported in their role. For example, one staff member said, "Two of the managers have sat me down to see how everything is going and if I needed any extra training. I feel supported here."

Most people told us they were satisfied with the quality of the meals they received. Comments from people about the meals included: "[They are] not too bad"; "It's adequate, not fancy"; and "[They are] quite nice".

Most people's dietary needs were met. The home did not have a cook, so meals were prepared by care staff. A menu for them to follow was advertised on the fridge in the kitchen and changed daily. A choice of main meals was not proactively given to people. Staff told us people could ask for something different if they didn't like the menu of the day, but nobody did this during the inspection and those with a cognitive impairment did not have the capacity to do this. However, a choice of two desserts was offered to people by showing them each option, which was effective. One of the managers told us they had considered showing photographs of meals to people to help them choose, although work to do this had not started. People had access to drinks of water throughout the day and were offered hot drinks at set times during the morning, afternoon and evening. We saw a range of drinking vessels suited to people's individual needs was provided.

Staff did not always provide consistent support to people to help ensure they ate and drank enough. One person required full support with their meal and we saw this was provided on a one-to-one basis in a dignified way. However, after serving meals to people in the dining room, staff withdrew without offering any support. We saw one person had difficulty eating their meal as it was not cut into small enough pieces for them. Another person started eating with their fingers but staff were not available to monitor how successful this was. At the end of the meal, staff returned to the dining room to collect the plates. People were asked if they'd finished but were not given time to respond. One person, who had not finished their meal, was given support to finish it, but this was done with some haste.

Staff monitored people's weight on a monthly basis and described the action they would take if people experienced unplanned weight loss. People who could not stand unsupported were unable to be weighed as the service only had access to stand-on scales. We discussed this with the registered manager who told us they had recently ordered a device to weigh people using a hoist sling. This would enable them to monitor the weight of people who were unable to stand.

During the inspection, some brightly coloured plates were delivered to the home. Experience shows that these can help people living with dementia to eat well as they are attracted to the vivid colours and can see the food more easily. The registered manager told us they would assess which people would benefit most from using these plates to support them to eat well.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. One person said, "They got a doctor when I was feeling off and the optician comes in." During the inspection, staff identified that one person was not responding well to antibiotics for a urine infection and contacted the person's GP for further advice.

Requires Improvement

Is the service caring?

Our findings

Most people told us staff were kind and caring. One person said of the staff, "They're helpful; nothing is too much bother. They'll get her a cup or water or a cardigan." Another person described staff as "Lovely". A comment in the home's 'comments book' stated: "Lovely to see [my relative] so relaxed and happy whenever I visit. She is well fed and cared for by kind, friendly staff. However, when asked what they thought of staff, one person told us, "No comment. They think too much of themselves and not the people who live here."

We found that staff were not always attentive to people. They had a tendency to congregate in the kitchen rather than spending time with people. When they did interact with people, some staff members were task-focused, did not actively listen to what people were saying and operated at a pace that was too fast for people living with dementia. For example, while serving lunch, a staff member saw a person was slumped in their chair and the chair was not close to the table. They asked the person if they were "comfy". The person replied, "Not really", but the staff member did not respond and left the person as they were.

While waiting to be served the evening meal, several people were heard to say how "confused" they were. They did not understand why they were sat at the table or what was happening. No staff member was present to support or reassure them. When staff started serving the evening meals, a person told a staff member "What I really want is a cup of tea." The staff member did not acknowledge or respond to this comment and continued serving meals to other people. When the staff member returned a few minutes later, with meals for other people, the person again said, "What I really want is a cup of tea." Again, the staff member did not acknowledge or respond to the comment but carried on serving meals. Around 10 minutes later, the staff member did serve tea to people, but without any explanation or apology to the person for the delay. This showed a lack of consideration. One person was registered deaf and used picture cards and a notepad to communicate with staff. Although the person retained a residual level of hearing and could lip read, some staff did not use these methods to enhance their communication with the person, but supported them in silence, using only the notepad.

However, at other times, we observed some positive interactions between people and staff. Staff used people's preferred names and approached them in a friendly and relaxed manner. For example, when medicines were being given, staff checked people were happy to receive them and explained what they were for.

Some staff showed a lack of knowledge about one person's religion and the needs of their faith. Whilst recognising that the person was not able to eat a particular type of meat, they did not understand why and could not tell us the person's religion. More senior staff had a better understanding of the person's faith needs, including the need to support the person to wash their hands before and after meals which they encouraged the person to do. However, there was little information about the person's faith needs in their care plan to enable staff to understand the person's needs. We discussed this with one of the managers, who agreed to add further information to the person's care plan to help ensure staff had the necessary information and knowledge to support the person's faith needs appropriately.

People's privacy and dignity were protected. When people were supported to use the bathroom, staff gave them the option of remaining with them or leaving them, to give them privacy, and returning later. Before entering people's rooms, we saw staff knocked, waited for a response and sought permission from the person before going in. When people received personal care, staff made sure doors were closed. Bedroom doors had a notice on them reminding staff to "Stop! Think dignity". Each person's care plan had information about ten key ways to maintain a person's dignity as a reminder to staff. A senior staff member told us they reinforced these principles to care staff at every opportunity. They said, "I try to make sure people are spoken to properly and treated with respect. I emphasise that it's their [people's] home and make sure staff use dignity screens [when supporting people] in shared rooms."

Staff described other practical steps they took to preserve people's dignity, such as explaining what they were about to do, checking the person was happy and willing to receive the support offered, and keeping the person covered as much as possible while helping them to wash. Three bedrooms were shared rooms. Staff had checked people were happy to share and were compatible.

People told us they could choose the gender of the care staff member, or request a particular staff member, to support them with personal care. This information was included in people's care plans, known to staff and followed. Confidential information, such as care plans, was kept securely and only accessed by staff authorised to view it

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identified relatives and people who were important to the person. People and family members confirmed that staff supported them to maintain their relationships; they were encouraged to visit at any time and to take the person out if they wished.

Staff encouraged people to remain as independent as possible within their abilities and to do as much as possible for themselves. For example, staff described how they let people attend to their own personal care when they could, but supported them by washing areas they were unable to reach or by gently reminding them when needed. Care plans also advised staff to promote independence. Typical comments included, "Enable [the person] to do as much as possible but provide support when needed" and then explained the tasks the person could manage on their own. A staff member told us, "I let [people] wash independently if they can."

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plans showed this process was on-going and family members told us they were kept up to date with any changes in the health of their relatives.

Requires Improvement

Is the service responsive?

Our findings

At out last inspection, on 11 October 2016, we identified a breach of regulation as people did not always receive personalised care. At this inspection, we found action had been taken but further improvement was required.

Care plans did not support staff to deliver personalised care to people as they had not been reviewed or updated since the last inspection in October 2016; therefore, they may not have reflected people's current needs. For example, we found there was a lack of information about the support a person needed with their catheter. A catheter is a device used to drain a person's bladder through a flexible tube linked to an external bag. Catheters can be prone to becoming blocked if good fluid input and output is not maintained. Staff had been trained by a community nurse to flush the catheter when it showed signs of blocking. Whilst there were some records of the person's fluid output, these were not kept consistently and had not been completed on some days, meaning staff may not have identified that the catheter was blocked. We had raised this as a concern at the last inspection but the person's care plan had still not been updated. We raised the concern again and by the end of this inspection information had been added to the person's care plan, including a chart to enable staff to monitor the person's fluid output.

One of the managers told us there were plans for care staff to update people's care plans, but they had not been trained to do this yet. The registered manager acknowledged the need for people's care plans to be reviewed and told us, "We've not reviewed the care plans yet as they would all be wrong as they don't have the capacity assessments in place." The lack of care plan reviews meant people were at risk of not receiving personalised care that met their current needs. However, staff demonstrated a good awareness of the individual support needs of people living at the home, including those living with dementia. For example, they knew how each person preferred to receive care and support; when people liked to get up and go to bed, and where people preferred to spend their day.

At the last inspection, we identified that the needs of people with diabetes were not being met. However, at this inspection we found staff were aware of the support people needed with their diabetes, including the provision of a low-sugar diet. Information was available to help staff identify the signs people would display if their blood sugar levels were too high or too low and records showed that blood sugar readings were taken when one person showed signs of being unwell. Staff also sought prompt medical advice when the person's condition did not improve. A doctor who had regular contact with the home told us, "Staff are now monitoring people with diabetes in a positive way." They added, "The way professionals visits are recorded [in people's care plans] is very helpful and allows us to see what colleagues have done."

Staff provided other examples of where they had responded appropriately when people were unwell. For example, they had identified four people who were feeling unwell and had arranged for them to be seen by a visiting GP on the first day of our inspection. When people were admitted to hospital, staff completed a 'hospital transfer form' to provide information that would assist medical staff to understand the person's needs. In most cases, a staff member also accompanied the person to aid communication between the person and hospital staff, particularly if they were living with dementia and struggled to express themselves

verbally.

People were only supported to take part in a limited range of activities and these were not run consistently. Time was set aside from 2:30pm to 3:30pm each afternoon for staff to run activities with people. However, staff told us they did not always have time to do this as the staffing levels had been reduced to two staff in the afternoons. This was confirmed by activity records that showed people only took part in activities two or three times a week on an ad-hoc basis.

During the afternoon of the first day of our inspection, people told us they were looking forward to an activity, but when nothing had begun by 3:15pm a person told us, "I don't think they've got anything coming." A quiz then took place shortly afterwards in the main lounge, which six people took part in and clearly enjoyed. They were asked to identify famous people from their voices and this led to conversation, reminiscence and some singing. Four people sat in a second lounge were not invited to take part in the activity; they sat in silence, without occupation, staring at the walls; one person fell asleep. When the activity was not taking place, people in the main lounge also lacked any form of stimulation, other than loud pop music that was being played. One person had been given a television for Christmas and one of the managers had agreed to install it in their room, but this had not been done. The registered manager told us they needed to arrange for an aerial to be installed first, but could not tell us when this would be done.

On the second day of the inspection, we met a school group who were involved in an initiative to visit the home for an hour every three weeks to meet and talk with people living there. People clearly enjoyed interacting with the pupils, which generated a lot of conversations, laughter and banter. One person's first language was not English, so the school had invited a pupil who spoke the person's first language and we saw them interacting positively with the person. The supervising teacher told us, "[People] get a lot out of it. It's a chance for them to interact; to meet with the community and share stories. The kids get a lot out of it too and are very comfortable here now."

A senior staff member had spent time with people discussing their backgrounds, interests and hobbies. They had then used this information to develop 'life journals' for people, together with suggestions for meaningful activities that would meet people's individual needs. These included games, arts and crafts, puzzles, gentle keep fit and reading aloud. Activity records, though, showed this information was not used consistently to provide mental stimulation to people.

People were supported and encouraged to make choices about aspects of their lives, including when they got up and went to bed, where they took their meals and how and where they spent their day. A staff member told us there was a bath rota in place, but people could choose how often they wished to bathe; for example, one person liked a bath nearly every day and records confirmed that they received these. One staff member described how they supported people living with dementia to decide what to wear; they said, "With [one person] if you ask what they want to wear they won't be able to tell you. The best way [for them] is to show them an item [of clothing] and they can say 'yes' or 'no' to it." Another staff member told us, "The majority of people can make choices. Some like to get up at 5:30 in the morning as they are used to it and that's fine. [One person] can point to one shirt if you showed them a choice of two. It's about what they want." Care records showed that people's choices were respected and accommodated. For example, an entry in one record said, "Asked [a person] if they wanted to go to bed; he didn't want to, so left in chair for 20 minutes, then found him in bed."

There were arrangements in place for people to provide feedback about the service. These included feedback forms that people or relatives could send to an external organisation who then posted the feedback on the provider's website. A 'comments book' was also available for people to leave feedback. We

saw comments in it were positive, particularly around events that had been organised, including a Halloween party and a Christmas dinner. The registered manager told us, "I'm here most days. If I see things are not right, I deal with them. If someone says they're not happy with something, I listen. Like I've started replacing people's curtains in their bedrooms." The provider had a complaints procedure in place, although no complaints had been recorded since the last inspection.

Inadequate

Is the service well-led?

Our findings

At out last inspection, on 11 October 2016, we identified breaches of eight regulations. At this inspection, we found action had been taken to address some individual issues but further improvement was required to meet all regulations.

Following the last inspection, in October 2016, we issued two warning notices requiring the provider and registered manager to take action to meet the requirements of regulations relating to consent to care and good governance by 10 January 2017. Although some steps had been taken to meet the regulations, we found they were still not being met fully. Mental capacity assessments and best interest decisions were still not being completed and the provider had not put any quality assurance measures in place to enable them to assess, monitor and improve the service. However, some individual issues raised within the warning notices had been addressed; for example, fire safety checks had been completed, action had been taken to better meet the needs of people with diabetes and staff had undertaken additional training in relation to the Mental Capacity Act. One of the managers told us, "We've been focusing on the issues in the warning notices and the report and getting those sorted out. Once that is complete, we'll start considering how to go forward and develop a [quality assurance] system. This was confirmed by the registered manager who said, "We're concentrating on getting everything done and up to date first."

The absence of an effective quality assurance system meant the provider was unable to confirm that they were meeting the requirement of the regulations. The registered manager told us they relied on care plan reviews to check people were receiving personalised care and treatment that met their current needs; but no care plan reviews had been conducted since September 2016 and we found people's care plans still did not include assessments of their capacity to make decisions or provide staff with information as to how to support a person with a catheter. There was no effective system in place to help ensure staff received appropriate training and induction into their role or that staff received appropriate support through regular supervision.

Following the last inspection, we also issued requirement notices telling the provider to make improvements in relation to: the display of their CQC performance rating; the notification of changes to the provider's registration; duty of candour; person-centred care; the management of medicines; staff training and support. The provider sent us an action plan detailing the improvements they would make to meet the regulations. We found some, but not all, of the improvements they said they would make had been implemented. For example, they published their CQC rating on their website; they made an application to re-register the service with CQC as a new partnership (a process that is in progress); and they introduced a duty of candour process to help ensure staff acted in an open way when mistakes occurred. However, action to improve the secure storage of medicines and to provide additional information in the care plan of a person with a catheter was only taken after we had reiterated our concerns during the course of this inspection. Whilst some additional staff training had been arranged, this had not been completed as study workbooks had not been marked. Five of the 11 staff members had received an appraisal, but arrangements for staff to receive regular supervision were still not in place. Therefore, the provider had not taken sufficient action to meet the requirements of all regulations.

The failure to act on feedback provided by CQC in the previous inspection report, and the failure to operate operate effective systems to assess, monitor and improve the quality and safety of the service provided, were continued breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their families did not raise any concerns with us about way the home was run and staff told us they felt more positive about the service than they did at the last inspection. They said they had been involved in monthly staff meetings where they were encouraged to express their views. They had also been given new roles and responsibilities; these included two 'manager' roles, a 'head of care' role and a series of 'champions', including: nutrition champion, dignity champion and end of life champion. The role of the champions was to raise awareness of their area of interest with colleagues. However, some staff expressed doubts as to whether the roles would be meaningful. For example, a staff member said, "They have asked me to lead on [a particular topic], but you raise things about it [with the registered manager] and they take no notice. I've said I'm not going to waste my time trying to improve [the topic area] if I'm not going to be listened to. They've given us titles, but don't allow us to carry them out as our ideas are disregarded." Another staff member said they were keen to implement changes but felt there was a "lack of time" and a "lack of direction". They added, "Nothing has filtered down to the floor yet. [Progress] is just slow. We've had team meetings, but change is very slow."

The registered manager told us that the new staff roles would take effect from 1 April 2017. They assured us the roles would be "meaningful" and that staff would be allocated protected time to work on their area of responsibility.

Some staff felt communication needed to be improved for the benefit of people. One staff member said, "There's a lack of communication between the staff team. For example, [one person] had a painful hand, but the information wasn't passed over on handover. When I was washing her hand she told us it was painful. If I'd known, I could have been more careful. Also, some staff don't tell you about falls. If we know, we can monitor to see if they're in pain and check they don't fall again." Another staff member echoed this and said, "Communication could be better. For example, after being off for a weekend, I wouldn't know what had been going on without reading through the handover [record]. There's nothing verbal, which there should be, as there's always more to it. You can read it on paper, but it doesn't give you all the information." One of the managers told us a lack of communication was one of the themes from the appraisals they had conducted. They said this would be addressed during staff meetings.

Some staff also felt the registered manager was not sufficiently visible in the home to provide on-going guidance, direction and support to staff. Comments included: "We don't see much of [the registered manager]. She only works alongside us if she has to; otherwise she goes up to the office. She covers the floor for us during [staff] meetings, but isn't present for them" and "[One of the managers] has worked really hard [to bring about change] but has been a lone voice." The registered manager told us she chose not to attend staff meetings, which were run by one of the managers. However, they were unable to tell us how they communicated their vision for the service or promoted a positive culture within the staff team.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that care and support were only provided to people with the consent of the relevant person. Regulation 11(1).

The enforcement action we took:

We took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems or processes to ensure compliance with the Regulated Activities Regulations 2014. They had failed to assess, monitor and improve the quality and safety of the service provided. (Regulation 17(1) and 17(2)(a).

The enforcement action we took:

We took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff received appropriate support, training, professional development, supervision and appraisal to enable them to carry out their duties. Regulation 18(2)(a).

The enforcement action we took:

We took action to cancel the provider's registration.