Porthaven Care Homes No 2 Limited

Woodland Manor Care Home

Inspection report

Micholls Avenue
Chalfont St Peter
Gerrards Cross
Buckinghamshire
SL9 0EB

Tel: 01494871630
Website: www.porthaven.co.uk

Date of inspection visit:
30 January 2017
31 January 2017

Date of publication:
29 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 and 31 January 2017. It was an unannounced visit to the service. This meant the service did not know we were coming.

Woodland Manor is a care home with nursing which provides accommodation and personal care for up to sixty four people. At the time of our inspection there were thirty five people living in the home.

Woodland Manor is made up of four units each which accommodate 16 people. At the time of our visit three units were operational.

The home did not have 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. An interim manager was in post and providing management of the service. The nominated individual was looking to recruit a manager to become the registered manager of the service.

This inspection was a responsive comprehensive inspection and was carried out in response to information of concern we had received. This was the first inspection of the service since it had been registered with us in December 2015. Therefore we looked at all of the domains to enable us to provide a rating for the service.

People and their relatives were generally happy with the care and were complimentary of individual staff members. They described staff as "Compassionate, patient, kind, enthusiastic, genuinely caring, so amazing, professional, genuine and always helpful". They told us the home had a happy welcoming atmosphere. However some people, relatives and staff told us the staffing levels were not always adequate. Two relatives told us it lead to inconsistent care for people.

At this inspection we found some people did not get the required level of staff supervision and support they required in a timely manner. People had risks assessments in place but not all areas of risk were identified. Risks were not reviewed and updated in response to changes in people's conditions.

Some people's medicines were not given as prescribed and medicine required for use in an emergency was not available.

Systems were in place to safeguard people and keep people safe. However the deficiencies identified in staffing, risk management and medicines did not always promote people's safety. There was also a delay in recognising and reporting safeguarding incidents which meant systems in place to safeguard people were not followed. We have made a recommendation to improve those practices.

People had care plans in place. Some were detailed and specific, whilst others were contradictory and not

updated as people's needs changed. We have made a recommendation to address this.

Some people's records were not suitably maintained and fit for purpose. This was because fluid and turning charts were incomplete, pressure damage assessments had conflicting scores and falls risks assessments were not updated to reflect increase in falls and management of the risk.

People were involved in making decisions on their care. The principles of the Mental Capacity Act 2005 were not followed for people who lacked mental capacity. This was because an MCA assessment was not carried out in respect of decisions on care and treatment. We have made a recommendation to address this.

People's health and nutritional needs were met. The majority of people and relatives were happy with the meals provided. People had input from other health professionals to promote their health and well-being.

Staff completed inductions. The provider had in place training to enable the staff to be competent in their roles. Staff felt supported. Formal one to one meetings and team meetings with staff were being re-established. Daily stand up meetings had been introduced and monthly head of department meetings were scheduled to commence.

Staff were kind, caring and promoted people's dignity. Some staff consistently promoted people's privacy, whilst other staff did not routinely do this.

The home had activity co-ordinators in post who provided a service to people over seven days. Activities were linked to people's interests and hobbies. People and relatives were very complimentary of the activity co-ordinator and the opportunities they provided to people.

Systems were in place to manage complaints. However complaints were not managed in line with the organisations policy. We have made a recommendation to address this.

Aspects of care were being monitored. Quality auditing was not fully established to ensure effective auditing. We have made a recommendation for monitoring of the service to improve.

The home had an interim manager who had made positive improvements in the short time they had been in post. They had identified and prioritised areas for improvement. They had put structures in place to support staff in their day to day work. People, relatives and staff were complimentary of the manager and their management style. They described her as "Effective, supportive, approachable and accessible".

The provider was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of 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.

People did not have sufficient staff to meet their needs.

Peoples' medicines were not managed and administered safely.

People's risks were not always identified and managed.

Staff were suitably recruited to safeguard people.

Is the service effective?

Requires Improvement

The service was not always effective

People were supported to make decisions about their day to day care. The principles of the Mental Capacity Act 2005 were not understood and appropriately applied when people were unable to make decisions on their care.

People had access to health professionals to promote their health needs.

People were supported by staff who were suitably inducted and had received training the provider considered mandatory. Access to specialist training and regular supervision of staff was being developed.

Is the service caring?

Good

The service was caring

People were supported by staff who were kind and caring.

People's dignity was respected, however some staff did not routinely promote people's privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had care plans in place which outlined people's needs. Some care plans were contradictory of the level of support people required and they were not updated as people's needs changed.

People were aware how to raise a complaint but the provider did not work to their own policy and procedure in relation to how complaints were managed.

People had access to activities and activities were linked to people's interests and hobbies.

Is the service well-led?

Requires Improvement

The service was not always well led

The service did not have a registered manager. An interim manager was in post and had started to bring about positive changes to the service.

People's records were not suitably maintained.

Quality audit systems were in place but not yet established as trends in accidents were not picked up and action from audits were not followed up on.

Woodland Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 30 and 31 January 2017. It was a responsive comprehensive inspection in response to information of concern we had received about the service. This was the first inspection of the service since it was registered in December 2015. We looked at all the domains in order to provide a rating for the service. It was an unannounced inspection which meant the provider did not know we would be visiting. The inspection was undertaken by two inspectors over two days. A specialist advisor whose speciality was nursing and dementia care was involved on day one of the inspection.

Prior to the inspection we reviewed information we held about the service such as notifications and safeguarding alerts. We contacted the Local Authority for an update on their involvement with the service. After the inspection we contacted health care professionals involved with the service to obtain their views about the care provided.

During the inspection we spoke with ten people living at the home. We spoke with one person by telephone after the inspection. We used the Short Observational Framework for Inspection (SOFI) to observe the care and support provided to other people in the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we walked around the home to review the environment people lived in. We spoke with the manager, deputy manager, and eight staff. We spoke with two relatives during the inspection and spoke to six relatives by telephone after the inspection. We looked at a number of records relating to individuals care and the running of the home. These included eight care plans, medicine records for eight people, daily

allocation sheets, rotas, health and safety records, audits, five staff recruitment files, staff training and staff supervision records.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we received information of concern that the home was understaffed and there was a high reliance on agency staff. We were informed people did not get the required assistance with eating and going to bed when they wanted to as no staff were available to assist. We also had concerns raised with us that a person who required one to one care did not get the level of supervision they required.

People told us staff were responsive to their call bells being answered but there was a delay in their care being met. One person commented "Staff are rushed off their feet, they come to turn off my call bell but are not able to provide the assistance I need at that time". Another person commented "During the week it takes 10 to 15 minutes for the staff to respond to the bell, but at the weekend it is really bad, sometimes it can be longer. I can understand this because there are other people who need looking after".

People and their relatives told us they thought the staffing levels were not sufficient. People told us at times they were supported by staff they did not know. One person told us "I was in another home before this one, they were more responsive." Another person told us "We (people who live in the home) have told them (management) we don't want agency staff. When you need help at night you don't want someone walking into your room who you don't know and have never met before".

Some relatives were happy that the staffing levels were sufficient. Other relatives said the home definitely seemed short staffed. They told us the weekends always seemed worse with more use of agency staff. Two relatives told us there was a lack of consistency in staff which impacted on their family members care. This was because they were supported by staff they did not know. One relative commented "There needs to be more support and supervision for people. Sometimes when I visit there are no staff with people in the lounge or dining room. I think a floater staff member would be helpful". Another relative commented "I can never see or find staff when I visit".

Throughout the inspection we saw there was a delay in people getting the support they required. Two people on the upstairs nursing unit were unsupervised with their meals. One of those people was on a pureed diet which would suggest they could be at risk of choking. One person called out for help for a period of 10 minutes but staff were not available to assist and did not hear them.

On another unit a person had their meal placed in front of them. The person made no attempt to eat it. Staff intervention and encouragement to eat was not provided until the staff member had finished supporting another person. This meant by then the person's meal was cold.

Two people told us that at 10.00 am they still had not had their breakfast. This was because they were late getting up as had to wait for staff to be available to assist them. We saw morning medication prescribed to be given at 8am was given as late as 11.15 am. This was because on day one of the inspection one nurse was responsible for medicine administration across the three units. The nurse commented " I started giving medicine at 08:00 hours and I hope to finish by 10:45 hours. We start giving afternoon medication by 12.30 hours". Medicines were not recorded as given later than prescribed therefore there was the potential risk

that people may not have the required gaps between doses.

Staff worked long days and were entitled to breaks. However staff breaks were not managed which resulted in sufficient staff not being available to support people during those times. A person asked a member of the inspection team to assist them. We went to look for staff to support them. There was only one staff in the unit at that time doing one to one observation. The staff member told us that one of care staff had gone for lunch but was due back shortly. A few minutes later a staff member arrived and attended to the person. Whilst on this unit a relative asked us for assistance as there was no staff available to deal with their enquiry. The director of nursing and quality visiting the unit attended to the relative and handed them over to a member of staff who arrived later.

Throughout day one of the inspection the one to one care provision was shared between two staff. We saw at times the person was unsupervised with both staff allocated to the one to one observation involved in other tasks. This was fed back to the provider who reinforced to staff that there had to be a delegated staff member with the person at all times

The home had a dependency tool which they used to calculate their staffing levels. The nominated individual told us they believed the staffing levels were sufficient but that staff were not deployed effectively. The tool used did not take account of the layout of the units which meant people who were deemed at risk of falls could not be observed when in the sitting room or dining room unless a staff member was in that area. The provider told us the dependency tool is designed to take into account the actual "hands on" care that a person requires and the layout of the home is irrelevant to the person's dependency. The dependency tool did not take account of people's nursing needs either. A person who presented with high needs was assessed on the dependency rating tool as having low needs. Staff confirmed the person had high care needs and required regular support and intervention. The provider confirmed the person was cared for as having high care needs but the care plan was inaccurate.

The nurses spoken with felt one nurse on shift and a medicine technician was not sufficient. They felt under constant pressure. One nurse commented "I am worried if something goes wrong it will be my pin number that it affects". Another nurse commented "There is a shortage of staff and not enough qualified nurses".

The deputy manager was actively involved in carrying out nursing tasks to assist the nurse on shift. They also covered shifts as the only nurse on duty as well as carrying out assessments of prospective new admissions and dealing with management tasks. The deputy manager had no administration time allocated to enable them to carry out their responsibilities as a deputy manager. The interim manager had already identified this as an issue that needed to be addressed. The provider confirmed the deputy manager's job role is to work on the floors and provide leadership. They told us there is an allocation of two days per week for administration duties but these are deferred if clinical care is required for the residents. On these occasions the home manager will absorb the administration tasks.

The home had a back up on call system which existed but the provider confirmed it needed to be more robust. Staff routinely called the deputy manager for advice even when she was off duty. Prior to the first day of the inspection the deputy manager was called twice. Once at 4.00 am and they were back on duty on a long day the following day. A staff member told us "Clinical support was given by the deputy manager even when she was on holiday".

Accident and incident reports were completed. These were reviewed and signed off by the manager. In November 2016, 14 falls were recorded. Seven of those were described as unwitnessed falls. There was no indication these had been investigated to consider why they were unwitnessed and if they were linked to the

staffing levels at that time.

At the resident/ relative meeting in December 2016 people and their relatives raised concerns about staffing levels and use of agency staff. They gave examples where their care needs were not meet in a timely manner. One relative commented "When I visited the previous week my [family member] was left in bed and it took 20 minutes to find a carer". There was no indication in the minutes this had been investigated.

This was breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.This was because sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed effectively to meet people's care and treatment needs.

Some risks to individuals such as moving and handling, falls, and the use of bed rails were identified and reviewed on a regular basis. However we noted they were not routinely and consistently reviewed when an event occurred. We also noted they were not always representative of the risk posed. For instance, one person had a falls risk assessment which was dated the 21 December 2016 and last reviewed on 21 January 2017. On the review it stated there was no history of falls, however the person had fallen on 21 December 2016 and 4 January 2017. These had not been reflected in the falls risk assessment. The same person had fallen twice on the 28 January 2017, which had resulted in an injury. The risk assessment had not been updated to reflect the increase in falls and to consider if any other measures were necessary to minimise the risks.

One person had a specific medical condition which required prompt management to reduce the risks of the person developing breathing difficulties and choking. The person had been prescribed medicine to immediately reduce the risk and staff were required to dial 999. On day one of our inspection the person's care plan made no reference to the condition and there was no risk assessment in place to identify and manage the potential risk. We asked the nominated individual to rectify this immediately. On the second day of the inspection we noted information had been placed in the person's file for staff to follow. However two staff on duty were aware of the condition the person presented with but were unaware of the risk and action to take. The third staff member was unaware of the condition, risks and immediate action required. This had the potential to put the person at risk of choking.

We observed that a number of beds had bed rails without covers. These bedrails were not secure in that they could be used. This put the people at risk of entrapment. The bedrails risk assessments stated that bedrails were not required by the person. Therefore guidance required them to be removed or secured. The staff nurse on duty confirmed the bed rails were not is use but was not aware that the bedrails should be secured or removed when not in use. The manager was informed and made arrangement for the bedrails to be removed or secured.

We observed two staff did not use best practice in moving and handling techniques when supporting people to move. The method used could have caused harm to the person being supported as well as to the staff member. We spoke with the moving and handling trainer. They confirmed staff were not trained to move people in that way. They agreed to follow this up as a matter of urgency with the staff concerned. After the inspection we received confirmation this had been addressed.

Risk assessments had been made for the risk of pressure damage. Where required people had been referred to the Tissue Viability Nurse (TVN). We noted where a treatment plan had been put in place by the TVN this was followed.

The environment was clean and the walls were fitted with rails to help support people with poor mobility.

The flooring was in good state of repair. All the areas were well lit. The corridors were wide and there were no hazards which could potentially obstruct people and cause falls. People could move safely with the use of aids such as wheel chairs, Zimmer frame and walking sticks. Staff used hoists to transfer people. Each person had their own sling. There were clear instructions in their care plans on their use and identified the level of assistance required for transfers.

Potential risks associated with the environment had been identified and managed. For instance a risk assessment had been written for use of the garden, it identified what actions were needed by staff to ensure people's safety. A fire risk assessment had been completed. Each person had a personal emergency evacuation plan. These were colour coded to quickly identify the level of support people needed in the event of a fire. Regular fire tests and fire drills were carried out. The response time of staff was assessed and if required the staff were spoken to about how to improve their response.

Equipment such as lifts and hoists were serviced. Safety certificates for utilities were in date. For instance a Legionella risk assessment had been conducted on 9 February 2016. A number of actions had been identified to be completed. We checked if these had been undertaken, we noted there was a record of progress made against actions required.

Systems were in place to manage people's medicines. The deputy manager confirmed they were responsible for ordering medicines. Records were maintained of medicines ordered, received and disposed of. One person's medicine records indicated they were self- administering their medicine. An assessment was in place to indicate the person was able to take responsibility for their medicine.

The home had a number of people who were diabetics which were insulin or tablet controlled. There was an emergency "hypo box" available which included dextrose tablets, jelly babies and glucose gel. These were suitable for people with hypoglycaemia which is low blood glucose who had the ability to swallow. The home also had people who could not swallow and they required glucagon. The home had run out of stock of the glucagon and the pharmacy had its stock recalled. This meant the home had none to use in the event of requiring it. The nurse told us they had informed the pharmacist they required stock of it. However they told us they had been so busy they had not had the opportunity to chase it up. This was handed over to the nominated individual to take immediate action on.

Interim prescriptions were handwritten on people's medicine administration records (MAR) and signed by two staff. However these were not always clear and as prescribed. In one person's MAR we saw that on discharge from hospital their medicine had been handwritten on their MAR. However one medicine was recorded twice when only prescribed once a day. This had not been identified by staff signing in the medicine. Another person was on reducing antibiotics however the MAR had the antibiotic written at the maximum dose with the instructions for reducing it underneath. Therefore it was not clear what dose was to be given. The staff nurse on duty confirmed "I find it confusing as to what the person is prescribed".

Another person had recently been discharged from hospital with a change in their medicine. We noted one medicine dose had been increased by the medical officer at the hospital. This was clearly documented in the discharge paper work and the hospital had sent a new prescription. The medical officer had also asked for the person's blood pressure to be checked by their own GP. We checked the MAR for the person. We noted no change had been made to the MAR since the discharge from hospital. We asked the registered nurse if the person had been receiving the increased dose of medicine. They informed us they had not as no-one had picked this up. We checked the handover notes from the discharge date, we could see no record this had been handed over and communicated to staff. This meant the person had not received the increased dose of medicine. The medicine concerned was prescribed to manage blood pressure. The

hospital had noted the blood pressure may have had a contributory factor in the potential risk for the person to fall. As a result the person not receiving the medicine dose prescribed had been placed at higher risk of further falls.

Medicines that required storage in the fridge were kept in the fridge. Labels were available to record the dates of opening of medicine bottles and creams. These were not consistently used. Two bottles had the opening dates written directly on the bottles, two bottles did not have the opening dates, and four cream boxes had no opening dates. This meant medicines could be used for longer than recommended after opening.

The medicine trolley was locked and secured to the wall in the treatment room when not in use. On one occasion we observed that the key to the clinic was on the door outside whilst the nurse was inside. The nurse realised this quickly on coming out and commented "I know this should not happen, I am multitasking". On another occasion when a person came home from hospital their medicines were handed to a staff member. The staff member put them in an unlocked drawer in the nurse's station. They did not inform any other staff member of this and as a result time was spent looking for the person's medicine.

The manager told us they had trained medicine technicians as well as nurses to administer medicines. On day one of the inspection one nurse was administering medicine for all three units. Nurses told us they administer medicine to people with diabetes first and people who have the same medicine more than once a day to try to ensure people get their medicines in a timely manner. One person told us "I don't always get my medication on time because the staff are very busy".

This was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because risks to people such as risks of falls were not managed and safe management of medicines was not promoted.

People told us they received safe care. People confirmed they knew who to speak to if they had any concerns about their safety. Whilst people told us they would tell staff if they had concerns they also told us they feared what would happen if they did speak up. One person commented "You have to think about the repercussions don't you." Another person commented "You have to be guarded with what you say." This was fed back to the provider to explore further with people.

Most relatives were happy with the care provided. A relative commented "I feel [person's name] get safe care, I have no criticism of the care provided". Another relative was dissatisfied with aspects of care and felt their family member was not getting the care they required.

The manager had contacted the Local Authorities Safeguarding team to request posters and information to be placed in public areas of the home. Safeguarding was discussed in relative and resident meeting to reinforce to people what to do if they had any concerns.

Staff understood how to identify signs of abuse and told us they would report any concerns to the management. Policies were in place to promote safeguarding. The training matrix indicated that 99% of staff had received safeguarding training. As a result of a recent safeguarding alert the Local Authority had identified there was a delay in reporting. They had asked the manager to review their training around recognising and reporting of safeguarding incidents to ensure this happened in a timely manner. After the inspection we were made aware of another safeguarding incident that was not reported to the Local Authority in a timely manner.

It is recommended the provider ensures that timely safeguarding alerts are made to safeguard people.

The service followed safe recruitment practices. Staff told us they completed an application form and had attended for interview. Staff files contained a photo, application form, medical questionnaire and evidence of an interview and written assessment. Records showed checks had been made with the Disclosure and Barring Service (criminal records check). Appropriate references were obtained to ensure staff were suitable to work with the people they supported. Registered nurses were checked against the Nursing and Midwifery Council (NMC) register. Monthly checks were carried out to ensure nurse's registration remained up to date.

Requires Improvement

Is the service effective?

Our findings

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 what actions had been undertaken and whether the service was working within the principles of the MCA and if any conditions on authorisations to deprive a person of their liberty were being met. We noted a number of DoLS applications had been to the local authority. None of the applications made had yet been assessed by the local authority. The new manager had begun to implement a tracking system for the applications made. It was intended that this would provide clear evidence of when an application had been made and when a decision had been provided. The manager was aware of the need to inform CQC when a decision had been made on an application.

Staff confirmed they had received training in the Mental Capacity Act 2005 and DoLS. During discussion with us they had an understanding of how this applied to the people they supported. However their practice would suggest they were not working to the principles of the MCA 2005. The home used an MCA assessment form which they completed when they had concerns about a person's ability to make a decision. The completed forms we saw did not demonstrate good understanding of the principles of the MCA. For instance they did not identify what decision the person was being assessed to make. In the section where the decision should have been recorded the person's medical condition was listed instead, for example dementia. This did not demonstrate an assessment of people's ability to make a decision.

We saw that a number of family members had signed consent forms on behalf of their relative. We checked with the provider if they had assured themselves if the third party had legal authority to act on a person's behalf. We were reassured these checks were in place. Where possible the service always sought consent from the person concerned. We noted staff sought verbal consent from people prior to supporting them.

It is recommended the provider works to the principles of the MCA 2005 and that MCA assessments are completed when a decision on care and treatment are required for people who may lack capacity.

People told us some staff were more skilled and knowledgeable than others. Relatives told us some staff had lots of experience but others seemed less trained. A relative commented "Definitely think staff need more training, especially in working with people with dementia". Another relative commented "Staff do not seem very well trained and training is not comprehensive. Staff do not think about their actions and do not use their common sense". A third relative told us the nurses are all very good and very capable. They commented " There are a couple of staff we talk with regularly and we have confidence in them to look after [person's name]"

Staff had access to induction and training. New staff completed three days induction training, were allocated a mentor and then worked in a shadowing capacity for the first three days on shift. An in house induction record was in place which was signed off when completed. Care staff were registered on the Care Certificate training. The Care Certificate is a recognised set of standards that health and social care workers adhere to in their daily work. This involves observations of staff performance and tests of their knowledge and skills. Three staff had completed their care certificate training and other staff were working through it. Nurses completed a competency assessment during their induction which outlined the competencies they had and areas they might need further training in.

Care staff told us they had been inducted into their roles and the home. Some nurses felt their induction gave them the information they required. A staff member told us "All staff undergo induction training before they can work on the units and then they have a period of 'shadowing' a member of appropriate staff. Our home trainer ensures that our ongoing training is updated and arranges for new training as required". They said all new staff members are provided with a list of tasks which they need to be signed off on, as competent, by a senior staff member, prior to working on their own. A nurse told us their induction was not what they expected. They commented "I had a very short superficial induction due to shortage of staff and demands of the home. As a result they had to find out the answers to things myself".

The provider had in place training to enable staff to be competent in their roles. These included training on fire safety, safeguarding vulnerable adults, infection control, manual handling, health and safety, challenging behaviours and dementia. Role specific training was provided for the catering and housekeeping staff. Nurses had access to training to support their clinical skills such as training in catheterisation, immunisation, tissue viability and syringe drivers. Some staff told us they required training on end of life care. The home had liaised with local hospices and the Local Clinical Commissioning Group to source further training for staff. The manager had identified staff as champions of various aspects of care such as nutrition, dementia, diabetes, continence and tissue viability. These roles were still being developed and training was being accessed to support staff in these roles.

Staff told us they felt supported and received supervisions. Records showed gaps in the frequency of supervision. The acting manager was aware of this and had commenced one to one supervision meetings with staff. They also held a group supervision meeting to reinforce to staff expectations of their roles, policies and procedures and planned changes to the service. New staff worked through a probationary period and were confirmed in post. Annual appraisals had not yet commenced as not many staff had been in post a year. The manager agreed these needed to be scheduled.

People felt their health needs were met. Relatives spoken with told us they were kept informed of any change in their family member's health and medical advice was sought. People were registered with local GP practices. A GP book was in use which outlined people who needed to be reviewed on the GP's next visit to the home. People had access to opticians, chiropodists, speech and language therapist, diabetic nurse and tissue viability nurse. A record was maintained of appointments with health professionals and actions agreed.

A professional involved with the home told us that during their visit to review a person, staff had a good knowledge of the person and their condition. They told us they found the person's records were very good and all the staff very helpful during their visit. They commented "The advice given was followed".

Other health professionals commented "Staff are extremely sensible in their approach to the patient's medical and care needs. I think the deputy manager is extremely competent and provides an excellent service". "The deputy manager has good in-depth knowledge of people and conditions".

The home had catering staff who were responsible for developing menus, ordering food stocks, rotation of stock and cooking the meals. The majority of people and their relatives were happy with the meals provided. The said the meals were nice and the portion sizes adequate. They confirmed they had a choice of meat, fish and vegetable daily. However they told us the menu did not always take their personal preferences into consideration. People told us they had recently had a meeting to discuss the food available. They were confident changes would be made to the menus to take account of their preferences. One person told us "The chef attended a meeting and we told him what we liked." Another person told us "I think that this is about to change because we have had a meeting where we are encouraged to talk about views on the service".

One person was less satisfied with the way the meat and fish dishes were cooked. This was feedback to the provider for the chef to follow up with the individual concerned. Information of concern we received prior to the inspection indicated that the food was of poor quality. They told us "Everything looks very unappetising and the portions are small". This was not evident during the inspection.

People had the choice to eat in the dining room or their bedrooms. They were offered a variety of drinks. We observed three meal times; the food was well presented and seemed to provide good nutritious value. Where required people were provided with either a pureed diet or a high calorie diet. There was a nice atmosphere in the dining rooms with people engaged in pleasant social interaction.

Staff we spoke with were knowledgeable about people's dietary needs. However the record of people with diabetes maintained by the kitchen staff did not correspond with the number of people who were diabetic. People's care plans contained guidance on their nutritional needs and risks. In one person's care plan the speech and language therapy assessment indicated the person required thickener in their drinks and a soft diet. The person's nutritional care plan made no reference to this. The staff member who had implemented the care plan confirmed they were aware the person's fluid needed to have a thickener added. However they were unaware the person required a soft diet. This had the potential to put the person at risk.

It is recommended the provider ensures all staff are aware of people's dietary needs and nutritional risks.

Records showed people were weighed monthly. There were care plans and MUST tool instructions for people with both low and high risk of malnutrition. In both cases the instructions were followed by the staff.

Good

Is the service caring?

Our findings

People who we spoke with told us which staff they had developed good working relationships with. For instance one person kept pointing to staff and told us "That one's good." A person told us there was a "Happy atmosphere in the home".

People told us the permanent staff on their units were generally caring. One person told us they had been unwell since Christmas and they were really well looked after. They commented "The carers are all very good". Another person commented "If you have can't live at home, this is as good a place as any to live". A third person gave us negative feedback in relation to an agency worker. They commented "We had one agency nurse, I don't know why they do the job, they just didn't care". We were not aware who the agency worker was to feedback to the provider.

Relatives were very complimentary about the regular staff. They described staff as compassionate, patient, kind, enthusiastic, genuinely caring, so amazing, professional, genuine and always helpful. They named specific staff that they had good relationships with and had confidence in them to provide good care to their family member. They told us they were always made to feel welcome and could visit at any time. Another relative described a staff member as "difficult" and took a casual approach to their work.

A relative told us they felt confident their relative was well looked after. They commented "[person's name] independence is promoted and they are happy which gives me confidence they are well looked after". Another relative commented "The company care about the quality of the carers, the staff adore [person's name] and [person's name] is comfortable with them. [Person's name] is happy living there". A third relative commented "Excellent care, I could not find a better place".

We observed staff were very considerate to visitors offering drinks and offering them privacy. One staff suggested to three members of the family visiting a person in the lounge "If you wish there is a room available where you can be together and have a bit more privacy". A relative commented "You always get a lovely welcome, regardless of who you are". Another relative commented The home looks after my dad really well when he is visiting mum. I find that really reassuring".

Staff demonstrated they had good knowledge about people, their likes and dislikes. Staff were aware of people religious beliefs and a religious service was held in the home on a regular basis.

We observed positive interactions between staff and the people they supported. Staff approached people in a calm manner. They provided explanation before giving care. Staff addressed people by their names and engaged with them when carrying out care. We observed that when a carer responded to the call bell she said to the person "I need to get somebody to help me, I shall not be long. Is this ok?" During meal times one staff member asked a person "Would you like me to help you put this apron on. It will protect your clothes". Staff did not rush people during lunch time, they sat near the person and did not rush them between spoonful's of their food.

One staff member got on their knees and close to the person in order to maintain eye contact during a conversation. Staff were engaging and encouraging people to eat their meal in a calm and discreet way. We saw appropriate use of touch, reassurance and distraction when people were becoming distressed.

Staff were able to make people feel at ease with them. We observed a lot of laughter among staff and the people they supported. We overheard staff talking to people in a respectful manner. People looked relaxed and comfortable in the company of staff. One member of staff had been away from the service for a few days, it was clear that people had missed them. The staff member also showed concerns for people and asked how they had been in their absence.

People's communication needs were detailed in care plans. For instance one person care plan stated that staff needed to speak very clearly and in short sentence. We observed how staff spoke with the person and they did follow the care plan. People told us they were involved in decisions about their care. We saw staff gave people choices in what they wanted to eat, drink, where they wanted to sit and were given the option to join in activities.

We observed mixed practise about how staff promoted people's privacy. For instance most staff always ensured they knocked the door of a person's bedroom before entering, however we observed a number of staff in different parts of the building who just walked into a person's room without knocking. We also observed that bedroom doors were left open when people were still in their rooms asleep. This preference was not always detailed in the person's care plan. When we spoke with staff they told us how they would support privacy and dignity whilst providing personal care.

People's care plans included an end of life care plan. Some people had a "Do not attempt resuscitation" (DNAR) form on file. These were signed by the GP and showed evidence of discussion with the person or their next of kin.

We saw that people on end of life care were kept clean, given oral care, sips of fluid regularly and analgesia when required. This promoted their comfort.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us their family member had been assessed prior to admission to the home. They felt the transition to the home went smoothly.

Pre-admission assessments were completed by a senior member of staff. The pre-admission assessment covered a wide range of a person health, life and wellbeing. Topics included consideration to allergies, social history and religious belief. On day one of the inspection the deputy manager was going to assess a potential new resident. We spoke with them on day two. They advised us they had gathered all the information and had identified a number of pieces of equipment the home required prior to the person being admitted. This was to ensure the home could provide safe and effective care.

The home had set timescales for a person's assessment post admission to be completed. This was based on what information was needed immediately to provide safe care. The home expected risk assessments to be completed within 24 hours of a person being admitted to the home and a life story to be completed within a month.

People had care plans in place. Relatives were aware care plans existed but were not actively involved in them. Relatives told us they contributed to the initial assessment but had not been involved since. A staff member commented "We should involve relatives to gather information on the person but due to the pressure and workload this is not always done".

Care plans were written for a wide variety of areas which people required support with. The care plans were detailed and gave staff the information they needed to ensure safe care and treatment was provided. Care plans were evaluated on a monthly basis. However some files we looked at had contradictory information in the care plan and other documents. Care plans were not always updated in a timely manner. For instance one person had been discharged from hospital four days prior to the inspection and their care plan had not been updated to reflect their change in need.

Another person's care plan indicated they were 'Fully Ambulant' yet the mobility assessment stated 'Needs assistance, unsteady on her legs, use Zimmer frame.' The same person's care plan stated '(name of person) is able to do self-care but needs some help with little things.' We asked the staff looking after the person how independent they were. The staff member told us they needed a lot of support but were quite reluctant to have support, so staff offered support regularly. This meant the care plan was not reflective of the person's current level of need and support required.

A third person's care plan indicated they had challenging behaviours and a chart was in use to record the behaviours. Throughout the inspection the person displayed some of the behaviours referred to as challenging in their care plan. However this was not recorded. Staff said "[Persons name] is always like this and it does not need to be recorded". This was not in line with what was written in their care plan.

The home was in process of introducing a key worker system. A keyworker is a named staff member who

works with a person in supporting them with their care and acting as a liaison between the person and their family member. Relatives were happy about that. They felt it would improve communication between them and the home to ensure their relative had everything they needed.

It is recommend that care plans are kept up to date, reviewed and reflective of people's current needs to ensure person centred care is consistently provided.

People told us it felt like they were starting to be listened too. One person told us how they had attended a meeting with the management. They told us they hoped the meetings would continue. The provider used a satisfaction survey to gain feedback from people using the service. In addition to the surveys the home was introducing a three monthly review with people and any family members involved in the person care. This was to ensure the care was still relevant and gave people and relatives a formal process to feedback about the care they received.

People stated "Although they did not have any concerns to report, they would know who to speak to and had confidence that it would be taken seriously". They could not recall if they had been given a copy of the complaints procedure.

Relatives felt able to raise concerns about their family members care. One relative commented "Concerns are always dealt with in a business like way". Another relative informed us their complaint was not investigated or responded to.

The service had a complaints procedure; We looked at the complaints log. There were clear guidelines for staff to follow in the event of a complaint being made. However the records viewed did not demonstrate the service followed its own procedure in that they did not respond to a recent complaint within the 28 days. The gaps in the management of complaints had been identified by the service and the manager was working on improving the way complaints were managed.

It is recommended that all complaints are responded to in a timely manner in line with the organisations policy and procedure.

Some people told us they choose not to engage in activities. Other people liked to participate in the activities available. Some relatives told us activities were provided. They were happy with the weekly programme of activities that was made available. Some relatives felt sufficient appropriate activities were not provided for people with dementia.

Care plans identified people likes and dislikes. Each person was asked to complete a questionnaire about their hobbies and interests. The home employed activities co-ordinators who worked across the whole week. We observed there was an advertised weekly programme of activities. People spoke very highly of the activities co-ordinators. One person told us "She is really good at her job, she gets us going." Typical activities within the home included, knitting club, art classes and cinema sessions. On day two of the inspection we observed the knitting club; this was a lively session, which was facilitated by the activities co-ordinator. The staff member was able to draw people into conversations and also promoted independence in people. For instance they encouraged one person to teach another person how to knit. This gave the person a sense of wellbeing and worth.

People told us they really enjoyed visits away from the home. One person commented "I really enjoyed the trip to Tring museum, we had a great time on the way home, we were listening to music, and she (pointing to the activities coordinator) took requests from us and then played the music we wanted. In that moment, I

could have been anyone, anywhere and I forgot I lived in a care home." Another person told us "I like to use the garden in the summer."

However one person felt there was not a lot to do in the local area. They told us "I lived in another care home, and I attended the local church and pub quizzes, there is nothing like that around here." However they went onto to tell us how they volunteered at the local homeless hostel. A member of staff had introduced the person to the scheme as they had got to know the person had a history of volunteering. The person told us they had always been an active member of the community and liked to help people. They commented "Keeping that going was important to them".

The home was developing community links. People had been involved in donating a sum of money to a local charity. They were getting involved in dementia friends, dementia coffee mornings and had links with local churches.

Requires Improvement

Is the service well-led?

Our findings

People's files were not kept up to date and fit for purpose. We noted a number of records had conflicting information in. One person's care plan had a pressure damage assessment which had scored the person at high risk; however the actual score of the assessment was recorded inconsistently for the same period of time. In one section the score was recorded as 21 and on a different form for the same period it was recorded as 17.

The care plans provided clear instructions and guidelines on how to protect people from developing pressure ulcers, but there were inconsistencies in their applications. For example a person's care plan clearly specified that they should be supported to turn in bed to relieve pressure on their skin every two hours. The records indicated they were turned four hourly. On another person's chart the frequency had been changed in the care plan but that information had not been transferred to the repositioning chart. The charts were not checked and signed.

Review of people's falls risk assessments indicated there was no changes when in fact there had been an increase in falls and no action was recorded as being taken. Some people's care plans indicated they required food and fluid monitoring. However there were gaps in recording and it was regularly not recorded if people had the desired input/output. Care staff told us the catering staff were responsible for completing the food and fluid chart. However they were not with people all day so were not aware who had drinks offered and taken. The manager confirmed the care staff were responsible for completing them.

Temperatures of the drug fridge (Min & Max) and the treatment room were taken daily. However there were gaps in the recordings.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because records were not suitably maintained and kept up to date.

Systems were in place to promote communication within the team. Staff were asked to read and sign to say they had read and understood relevant policies, procedures, people's care plans and risk assessments. Staff were expected to complete daily reports on individuals. Handovers took place at the start of each shift to inform staff of changes in people. A communication book and dairy was in use and a daily "Stand up meeting" took place with heads of departments to ensure staff were informed of what was planned in the service for the day. Staff confirmed these systems were in place to promote good communication and team approach to care. However key information such as risks and changes to medication were not communicated and acted on.

Some relatives told us the communication between them and the home was good. Other relatives told us communication was poor. This was because they were often given conflicting information and information was not passed on.

It is recommended the provider improves communication and put systems in place to promote safe and

consistent care to people.

The provider had systems in place to audit the service. An infection control audit was completed in May 2016. The manager was responsible for carrying out monthly audits of practice such as audits of care plans, pressures sores, weights, diabetes, medication, training and supervisions. Accident and incidents reports were completed but trends had not been picked up and addressed in accident reports for November 2016. The nominated individual carried out a monthly visit and reported on it. The actions from the audits were added to the homes action plan. We saw actions from previous audits were not followed up and signed off as completed. The provider confirmed this was because actions had not yet been completed. However actions from audits need to be timed to ensure they are acted on in a timely manner.

It is recommended the provider ensure trends in accident are investigated and action plans from audits are completed and signed off in a timely manner to satisfy themselves the service is being effectively managed.

The home did not have a registered manager. The previous registered manager left on the 5 December 2016. An interim manager was in post from the 3 January 2017. There was a deputy manager who was also a nurse and they were responsible for the nurses, team leaders and support staff. The deputy manager was experienced and very knowledgeable about the people living at the home and the care they required. They had a visible presence on units trying to influence the care in a positive manner. They provided hands on support and guidance to staff. The deputy manager had many roles and responsibilities which included deputy manager responsibilities and regularly covering shifts. The interim manager had identified that the expectations of the deputy manager's role was unrealistic. They had taken some of the management responsibilities from them such as auditing to enable the deputy manager the time to do other aspects of their job.

People and their relatives were complimentary of the interim manager and deputy manager. A person commented "I like her, I am impressed with her. She seems effective". A relative commented "The feeling on the ground is that [interim manager's name] is respected". They said "The deputy manager seems to be all things to all people". Another relative told us they were very pleased with the change in manager. They told us they had already seen changes in staff attitudes and the manager had a visible presence in the home.

We had received information of concern that there was no manager or deputy manager in the home over Christmas and that it felt like staff were running the home and not the provider. A staff member told us "During the Christmas period when the home was without a manager there was no support from the company and nurses had to deal with most of the problems. A colleague tried to contact head office several times but there was no answer". The nominated individual told us management were available and on call on specific dates over the Christmas and new year period. They advised they were in regular contact with the home. The feedback from staff contradicted this.

Staff felt the interim manager and deputy manager were accessible and approachable. They felt the interim manager had made positive changes in the short time they had been in post. One staff member told us "I feel I can go to the manager with any problem and she tends to sort it out there and then". Another staff member commented "We believe we can approach our new manager and discuss issues as required". A third staff member commented "Since the 1st of January the support is improving. Before that we had little support from management".

The interim manager was new to the organisation and was getting to know their policies and systems. They were clear of their expectations from staff and had reinforced to staff what those expectations were. They had introduced a staff nomination system so good practice could be recognised and celebrated. This was to

motivate the staff and thank them for their hard work and commitment. The interim manager had identified areas for improvement. They had an action plan in place which outlined priorities and timescales for improvement. This was work in progress.

People and some relatives told us they were given the opportunity to feedback on the service. Meetings took place which enabled them to comment on the service provided. Some relatives told they were not formally invited to relative meetings and would only be aware of it if they happened to see a notice when they visited the home. A resident questionnaire was carried out which showed people were asked to rate their care, food and drink, leisure and wellness, customer care, home environment and asked people for recommendations for improvement. The analysis of the feedback suggested people were happy with those areas of care.

The provider is required to notify CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. There had been below expected notifications for the service type since the home had been opened. The interim manager was aware of their responsibility to report and had made the required notifications to the Commission during the time they had been in post. However senior staff were not suitably trained to complete notifications in the manager's absence which resulted in a delay in notifications being completed. The interim manager informed us they were coaching the deputy manager on how to complete notifications to ensure from now on they were completed at the time.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not managed and safe management of medicines was not promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not suitably maintained and kept up to date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed effectively to meet people's care and treatment needs.