Ermington House Ltd

Kingsacre Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 was completed on the 25, 26 September and 2 October 2018. The first day was unannounced, but the subsequent days were announced to enable us to meet with key staff and give feedback.

Kingsacre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The provider took over this service in June 2018, when it still provided nursing care, however since July 2018, they no longer provide nursing care on site. This is obtained from the community nurse team when needed.

Kingacre accommodates 34 people in one adapted building. The building is situated in a rural location standing in its own grounds. Communal areas are situated on the ground floor with bedrooms on the ground, lower ground and first floor, all accessed by a lift. The building is old and in need of some refurbishment.

Shortly after taking over this service the nurse team resigned, leaving the home very short staffed in terms of being able to cover nursing shifts. The provider made the decision to make the service a care home without nursing. They have worked with commissioning teams to review and move those people who required nursing care. They were in the process of changing the home's registration so that it would no longer provide the regulated activity associated with being a nursing home.

This inspection was brought forward because of a number of safeguarding concerns which are being investigated by the local authority. This resulted in the service becoming part of a safeguarding process. This meant the local authority safeguarding team, commissioners, CQC inspectors, police and other professionals had met to discuss the safety and well-being of the people living at the service. The provider, their operations team and the registered manager had been part of these discussions. The findings of our inspection have also been shared with the local authority, so that they can form part of the safeguarding process. As part of this safeguarding process the provider had agreed not to admit any new people and the local authority have placed a hold on using this service for placements until improvements have been made. The death of one person and the circumstances surrounding that death were being looked at as part of a separate CQC process and does not form part of this inspection.

There was a registered manager in place who was also the registered manager of another service owned by the provider. 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. The registered manager and provider had recognised that the current management arrangements were not working. The provider had employed another manager who

would be applying to register with CQC to run Kingsacre. When this has happened the current registered manager would return to managing one service.

Some aspects of the service were not safe and placed people at potential risk. These included:
•□Poor recruitment processes which meant staff were employed before all checks to ensure they were suitable had been completed.
•□Fire safety information and risk assessments were not completed in a consistent way to ensure staff had reliable and correct information in the event of an emergency evacuation.
•□Not all windows had restrictors fitted, and there were no regular checks to ensure restrictors were still in working order.
•□Hoist slings were not used for a single person's use- they were kept in communal areas and not named for individuals. This was an infection control risk.
•□There were no risk assessments in place for bed rails, we identified one person had sustained an injury when their leg was caught in a bed rail without a protector being used.
•□An oxygen cylinder had been placed next to a hot radiator in one person's room- this was removed to a safer place when we fed this back, but the service was not even sure if the person still required oxygen.
•□Some prescribed medicines were being used for people they were not prescribed for- i.e. thickener was found in one room which was prescribed for someone else. Systems for the use of topical creams needed improvement.
•□Some areas of the home were not safe. The patio/balcony area had an uneven and wobbly floor. There was also an area of the home where carpet was old, worn and beginning to ruck, which was a trip hazard.
•□Wheelchairs did not always have footplates. This placed people at potential risk of having their feet dragged when being transported, which could lead to injury.
•□Pressure cushions had been used on top of cushioned chairs which altered the seating position of some people leaving their legs dandling and placing them at more risk of pressure damage.
•□Not all pressure mattresses were set at the right setting for people's weight.

Following the inspection, the provider wrote to us to say action had been taken to address and mitigate some of these risks. This included updating risk assessments, providing further training to staff and liaising with healthcare professionals to gain the right healthcare information for people. Detailed actions about how the service mitigated the risks can be found in the section related to safe.

Our observations of the days we inspected, as well as feedback from people's and staff showed there were key times when there was not sufficient staff for the number and needs of people currently living at the service. Staff confirmed that most days they were still assisting people to get up right up to 12.30pm. The provider did not have a dependency tool to show how they had worked out staffing levels based on people's individuals needs and dependency levels. During the morning people were left for long periods in the communal areas without supervision or support. Some people may have been at risk of choking and there was no staff having an oversight of people in the lounge and dining area throughout the morning.

Staff did not have the right skills and competencies to ensure people's healthcare needs were being met. This was being addressed with some additional training and support from the community nurse team. The service had not always ensured new staff had an induction, or that there was ongoing support and supervision for staff to enable them to discuss their role and any training needs. Recruitment was not robust and placed people at potential risk.

The management arrangements were not clear to staff, staff did not feel valued or appreciated for the work they did. The provider said they would address this. They had already appointed another manager as they

had recognised the current registered manager was struggling to manage two locations.

Quality audits had failed to pick up on aspects of health and safety, records and lack of meaningful engagement for people.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, recruitment, the Mental Capacity Act (2005), safe care and treatment, person centred care and good governance.

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?

Inadequate

The service was not safe.

Medicines were not always safely managed.

People were not kept safe because recruitment procedures were not robust.

Staff understood what to do if they had concerns around abuse.

The service was not always staffed at an appropriate level to safely meet people's needs.

The premises and equipment were not always maintained to keep people safe. Actions had been taken to reduce the risks we identified.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider took over the service in June 2018 and was committed to improving the environment. This was work in progress and some areas of risk needed to be prioritised.

Staff lacked relevant training to enable them to provide effective and safe care to people.

Staff did not always understand their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Appropriate applications had not always been made to the DoLS team and best interests decisions were being made where people lacked capacity, but this was not well documented.

People were supported to maintain their health, although staff lacked skills and knowledge in some health conditions.

People's nutritional needs were well met.

Is the service caring?

Good

The service was caring.

People, relatives and professionals said staff showed a caring and compassionate attitude.

Some staff went the extra mile coming in on their days off.

Staff relationships with people were strong, caring and supportive.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not contain information to help staff support people in a person-centred way. Therefore, we could not be sure care was delivered in a way that best suited the individual.

People's social needs were not fully met.

People and those that mattered to them, were able to raise issues, concerns and compliments.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management team had not established a strong, open and visible culture within the service. Staff felt undervalued. The provider was addressing this with the introduction of a new management team.

Quality assurance systems in place to review and assess the quality of service and monitor how it was run were not always effective.

Accidents and incidents were reported and appropriate action taken, although this was still work in progress.

Kingsacre 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 25, 26 September and 2 October 2018 was unannounced on the first day. The first day of the inspection was completed by two adult social care inspectors, a pharmacist inspector, a specialist advisor in nursing for dementia and an expert by experience. An expert by experience is someone who has had direct experience or their relative had used registered services such as care homes. The lead inspector returned on the second day, which was an agreed date, to review further information and speak with staff. The pharmacist inspector visited on 2 October 2018.

We looked at all the information available to us prior to the inspection visits. This included notifications sent by the service, any safeguarding alerts and information sent to us from other sources such as healthcare professionals. A notification is information about important events which the service is required to tell us about by law. This inspection was brought forward due to a number of safeguarding alerts and information of concern we had received. We did not therefore ask the provider to complete a provider information return (PIR). The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with eight people. However, some other people were not able to comment specifically about their care experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We also spoke with two relatives. We spoke in depth to the registered manager, administrator, director, three nurses, lead person for induction training, eight care staff, two housekeeping staff and the maintenance person. We received feedback from four healthcare professionals.

We looked at four care files including risk assessments, care plans and daily records. We reviewed medicines records, three recruitment records and a variety of records relating to the auditing of the environment and quality of care.

Inadequate

Is the service safe?

Our findings

When asked most people said they felt safe if asked that question directly. Also, that it was "Nice here" or "It's a good place" and very typically 'I've got no complaints" "It's lovely here…always busy – always someone doing something."

Some aspects of the service meant people were placed at risk or potential risk. We fed back that the service was unable to evidence that enough staff had received emergency first aid training to ensure people's health and safety. In an emergency when lifesaving procedures may be needed, staff had not had training to do this. The provider agreed to action this as a matter of urgency. They arranged for an emergency first aid course to be delivered to staff the following week.

We found people's emergency evacuation plans (PEEPS) were inconsistently colour coded. This meant there were inconsistent instructions for staff to follow as to whether one or two staff would be needed to help evacuate people in an emergency. The fire risk assessment was also in need of updating. It stated the meeting point was the dining area. We were concerned that in the event of a fire staff would not have the right instructions to safely evacuate people. We also saw one emergency fire stairwell was full of bird dropping and there was no equipment near this exit to help people who were not mobile to go down the stairs. The registered manager said they had a scoop but this was downstairs. We highlighted our concerns to Devon and Somerset Fire and Rescue Service who had recently completed an inspection but not yet fed back to the service.

Since the inspection the provider has sent us the following information "PEEPS have been reviewed in the light of current residents needs and the colour coding has been updated to be consistent throughout. The Fire Exit you highlighted is being cleaned and de cluttered to aid evacuation prior to complete renovation and refurbishment in line with our planning application. This area will form an integral part of the lounge area with new external fire doors etc bringing the whole exit inside. Additional Fire Exit signage has been purchased and erected in strategic locations to aid evacuation. A new Evacusafe 3 Wheeled Fire evacuation chair has been purchased along with 2 fire evacuation sledges."

Some aspects of the building and equipment placed people at potential risk. Not all windows had restrictors fitted and there were no regular checks to ensure restrictors were still in working order. Hoist slings were not used for single use - they were kept in communal areas and not named for individuals. This was an infection control risk. There were no risk assessments in place for bed rails, we identified one person had sustained an injury when their leg was caught in a bed rail without a protector being used. One patio balcony was wobbly and had uneven flooring.

Following the inspection, the provider stated these risks had now been mitigated with the following actions. "Window restrictor had been fitted to the landing window and a reporting log has been included in the handyman's duties for regular checking. Patio balcony had been made temporary off-limits for Residents. The seasonal weather does not lend itself for residents being outside in this area. Currently people are offered a walk or wheeled within the grounds to enjoy the seasonal colours and enjoy the wildlife etc.

weather permitting. Again, the patio balcony area forms part of our renewal and building plans which should start within the next few months. A risk assessment has been completed for all those who use Bed Rails. We have ensured that those who lack capacity and use bed rails have a Deprivation of Liberty Safeguards (DOLs) in place."
There was a huge amount of equipment scattered around the home, which for the most part seemed redundant. Not all wheelchairs had footplates and feedback from some staff confirmed they were often short on footplates to ensure people's safety when transporting them around in wheelchairs. Following feedback, the provider has written to say slings have been labelled for single use and were now being stored in people's bedrooms. They have looked at their stock of wheelchairs and ensured all those in use have footplates attached. They were also considering purchasing further stand aid equipment and had put in place. They had also updated and ensured that appropriate inspection forms were in place for all moving and handling equipment.

Risk assessments were in place for some risks that people needed support to manage but others were not in place. For example, one person had a moving and handling risk assessment and an assessment of their likelihood to fall, but there was no risk management plan in place for their epilepsy. New staff coming in to the service would not have known how to support this person to manage their epilepsy or what to do if they had a seizure. We also saw for one person with Chronic Obstructive Pulmonary Disorder; a condition that can make it hard to breathe, they had oxygen stored in their bedroom next to a radiator. There was no mention of this in any care plan or risk assessment regarding how to store or use it safely or in what instances the person might need to use it. Staff did not have directions as to signs the person might be feeling unwell and what to do next.

We asked a senior staff member to ensure the oxygen was stored safely and it was moved immediately. They said the person didn't use it as much anymore now the weather was cooler and we fed back there was no management plan around this person's health needs in their care records which may have placed them at avoidable risk of harm. Following the inspection, the provider had written to us to say "We have requested a current assessment from the GP regarding the need for (one person's) oxygen and are awaiting the outcome. We have ensured a current risk assessment is in place for the storage of oxygen in this resident's room and have ensured that the PEEPs reflect this, along with the Fire Plans for the Brigade which have been clearly marked."

Staff managed medicines in a way that did not always keep people safe.

There was a medicines policy but it was not specific to the home and had not been read by all staff trained to administer medicines. Several new staff had recently been trained to administer medicines. These staff had been observed to ensure they were following best practice, but there was no ongoing process to assess their competence and identify future training needs. Medicines errors were responded to individually, but were not recorded or used to improve systems safety. The provider has since assured us that there were ongoing competency checks completed.

The provider was working closely with a new pharmacy for supplies of medicines and medicines administration records (MARs). There was a large quantity of some people's medicines in stock. The provider had arranged for any medicines that were no longer needed to be returned to the pharmacy and was working with the GP and pharmacy to reduce the over-ordering of medicines. Medicines were stored safely and securely. However, staff did not keep records of the fridge temperature and could not be sure that medicines which required refridgeration were stored according to the manufacturer's directions.

Prescribed medicines were not always used for the person they were prescribed for. In one person's room we found a tin of thickening powder that had on it another person's name and prescription label. We asked a member of staff to remove it. Staff later came back to us with the explanation that there had been a pharmacy error and too many had been delivered. We explained that medicines should only be administered to the people they had been prescribed for and any overstock should be returned to the pharmacy.

Staff did not have any information or guidance to help them decide when to give a medicine prescribed to be taken 'when required'. We saw that people received some of their 'when required' medicines regularly. Staff did not record the outcome of giving 'when required' medicines, so could not always be sure that they were effective.

Where people used specialist air wave mattresses to help reduce the risk of developing pressure damage, there was no system for checking these were on the right setting for the person's weight. We found three which were on the wrong setting and asked the senior carer worker to rectify this.

All the above show a breach in regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were administered by staff individually and staff signed MARs when people had medicines administered or recorded a code if a medicine was not given. Changes to the medicines supply and MARs meant that staff had to perform additional checks when administering medicines. This meant that the morning medicines round sometimes was not completed until nearly midday. Staff ensured that essential morning medicines were administered at the right time and that the gap between doses was safe.

Our observations on the days we inspected, people and staff views showed there were key times when there was not sufficient staff for the number and needs of people currently living at the service. Staff confirmed that most days they were still assisting people to get up right up to 12.30pm. The provider did not have a dependency tool to show how they had worked out staffing levels based on people's individual needs and dependency levels. The registered manager said they had been looking for a tool, but, at present, based staffing on the number of occupied beds. The staff rotas showed that on most days there were four care staff and one senior, who spent most of the morning administering medicines. This meant that four staff worked across three floors to assist people to get up and washed and dressed ready for breakfast. During the morning people were left for long periods in the communal areas without supervision or support. Some people had been assessed as being at risk of choking; however, there was no staff were designated to have an oversight of people in the lounge and dining area throughout the morning. Care staff were supported by two kitchen staff, two cleaners and a full-time maintenance person. These ancillary roles did not provide direct care and support to people.

Staff reported they were often rushed and felt they could not always provide a quality service for people because of the high number who needed support to wash and dress. One staff member said "We want to make sure every person has a wash or shower each day. This is not easy to achieve with four staff. We do struggle to get everyone up at a reasonable time." Some people felt the service was short staffed. Comments included "They're understaffed." When asked whether, or how, this affected them they didn't provide any examples but just reiterated that "Staff do their best seeing as they're understaffed."

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People were not fully protected from the risk of possible abuse. This was because recruitment processes were not robust. The service had not ensured that all relevant references and checks were in place before employing new staff, including disclosure and barring service checks (DBS). This meant they could not be sure new staff were suitable to work with vulnerable people.

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

The home was surface clean, despite carpets being stained and old. Some of the floors appeared uneven and some carpets were rucked. The provider was working on a programme of refurbishment and said they would be replacing these shortly. There were dedicated cleaning staff in the home that cleaned bedrooms and communal areas on a regular schedule. There were no records of what had been cleaned but the cleanliness was of an acceptable standard and did not place people at risk. We saw gloves and aprons being used when appropriate to manage infection control and the risk of contamination when providing personal care and handling soiled linens. We did feedback that we saw in one person's room an unwrapped catheter bag attached to a bed with the tube uncovered and dangling on the floor. This posed an infection risk to the person with the catheter and it needed disposing of. This was done so straight away.

Requires Improvement

Is the service effective?

Our findings

Care staff did not have the skills or training to be able to support people with more complex health conditions. Although community nurses managed injectable medicines for people with diabetes, care staff did not have the skills or training to be able to identify when people may have high or low blood glucose levels. Some people were prescribed a medicine to control seizures. Staff had not received any training on seizures and could not describe what action they would need to take if someone had a seizure.

Visiting health professionals fed back to us they did not feel care staff had the necessary training to be able to perform their roles effectively. They told us they were concerned that staff might not be able to identify when a person was becoming unwell and how to interpret observations of a person such as their temperature and blood pressure. One health professional said, "I don't think they would recognise a deteriorating patient", another said they were "Worried about people being left and people feeling staff are busy and don't want to communicate pain or discomfort, staff aren't vigilant or knowledgeable." A visiting professional explained they thought staff lacked some experience and said they didn't know what to look for. They showed us one person who was having their leg supported but the support wasn't in the correct place causing the person discomfort. One person needed to be referred to a continence service due to their changing needs. However, this had not been identified by care staff or management and therefore a visiting health professional had had to prompt the referral.

The provider was working with the safeguarding team, clinical commissioning group and community nurse team to get training in place so staff had the skills in understanding people's healthcare conditions. The provider said they felt that when there were nurses at the service, the care staff just referred everything to them. The nurses left in July 2018, and care staff were having to now use their own observations and call on the community nurse team when needed. The community nurse team were visited daily so could support staff in ensuring people's healthcare needs were being met. However there had been a failure on the provider and registered managers part in not ensuring staff had the right competencies and skills. This included induction training for new staff. We asked to see documentation to demonstrate new staff had received an induction but the registered manager was unable to locate this. One new member of staff, who was also new to care, said they were unaware of the need to complete the Care Certificate. The Care Certificate is a national set of standards to ensure new workers understand how to deliver care effectively.

There was no system to ensure the registered manager was able to easily tell which staff had completed or refreshed training they were required to do. Staff records did not contain complete information about training the registered manager said staff had completed. The registered manager said that the previous owner may have taken some of the paperwork so they did not have certificates of training for all staff. They acknowledged they needed to prioritise training to ensure staff were competent to work with people with complex healthcare needs.

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

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA). 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 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 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).

The registered manager said one person had a DoLS authorisation in place but the previous owner had taken the paperwork and they were in the process of getting further copies. There were others who may have lacked capacity and were certainly under constant supervision, but they had not had their capacity assessed or consideration of their rights under DoLS. Since the inspection, the provider has said they have considered each person's capacity to make particular decisions. The provider said they were in the process of making the applications to the DoLS team. They also said they had looked at best interests for people where bed rails were in use.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood the principles of ensuring people had maximum choice and gaining consent. We saw examples of this in practice. For example, asking people where they wanted to have their lunch, what type of cold drink they would like. All staff had received training in MCA and DoLS however they were unclear about what this meant in practice.

The registered manager and provider had taken steps to improve communication in the home and, although it was improving, it still was not fully effective. We received feedback from visiting professionals that it was sometimes hard to get hold of the registered manager and care staff often did not know where they were or who was deputising in their absence. Daily records showed where something might happen and it would only be partially handed over. For example, if a person bypassed their catheter and it leaked it was included on the handover sheet but not what to do if it continued to do so. We saw that a visiting GP had recommended a new skincare regime for a person on 9 August 2018.This had not been implemented or added into their care plan despite the record showing it had been reviewed on 30 August 2018. This showed that important information about people and their needs was not being shared with all staff and records were not being updated when new information was received.

Care plans were not effective in communicating to staff how they should perform care or support people to meet their personal care needs. The language used in care plans was vague such as "assistance needed" rather than a description equipping staff with the knowledge of how to do their job effectively. The registered manager had been working closely with the local authority quality assurance team to improve plans, but acknowledged they were work in progress and still required more detailed information. The provider said following inspection, they had been in touch with all GPs to gain a greater understanding of people's healthcare needs and what they needed to monitor.

Everyone we spoke with liked the food, one person said, "I used to be a cook its really good here", another said "I do like the food yes, lunch was nice." Throughout the day we saw people had drinks within their reach and staff were offering drinks regularly. However, the mealtime experience at lunchtime required

improvements. There were no table cloths and no menus to tell people what was on offer. Condiments were not offered routinely. We saw one person ask for vinegar and a care worker went to get it. People who required assistance to eat the meal was given this once everyone else had been served. Staff sat with these people and spoke about what was on the plate. The TV was on loud in the lounge where more than half the people were eating. No one was watching this and it detracted from any conversation or relaxed ambiance.

The kitchen staff were aware of people's likes and dislikes and who required a modified diet due to risk of choking. People were asked for their meal choice for the following day. This may be confusing for people living with dementia. Meals were pre-plated but consideration had been given to whether someone had a smaller appetite and whether they enjoyed or wanted the main meal being offered. We checked people's weight were being monitored and this was done either weekly or monthly. From the records, people's weight was being maintained. Some people had been referred to the GP for fortified drinks where their appetite and weight had reduced.

People were supported to access healthcare services, a district nurse visited the home daily and we saw evidence people had gone to appointments at the local hospital. The registered manager said they were looking at home visits for regular chiropody, eye care and dentistry, for those unable to access community facilities.

Good

Is the service caring?

Our findings

People said staff were kind and caring. Some people had favourite staff and one person decided some were better than others. No one said staff were not caring. One person said, "They are very busy so it's hard for them to spent too much time, but they are kind."

We observed kind and caring interactions throughout the day from care staff towards people living in the home. Care staff showed they knew people and their needs and could pre-empt some people's requests. We saw appropriate touch being used and people being comforted when they needed it, if they were cold they were given a blanket, and one person had a soft toy to stroke to sooth them. Two staff spoke about coming in on their days off to provide either extra activities or to simply sit and talk with people. This showed a really caring attitude.

There was a volunteer in on the first day of our inspection, who was also a member of staff who came in on their time off. They organised some games and talked with people, providing a positive influence on the environment. People smiled and laughed with the volunteer and we saw how they could encourage people to join in the social games they had set up. One person said they were feeling low so the volunteer encouraged them to be the bingo caller and the person was smiling by the end of the game.

People's rooms had family mementos and personal touches such as photographs and books and ornaments, giving them a homely feel.

People's privacy and dignity was upheld. For example, we saw a member of staff organising for someone to see a community nurse in a separate room with a screen. We saw care staff knocking before entering people's rooms. The two toilets next to the lounge did not have locks and could compromise people's privacy and dignity. The provider said he was going to make a partition wall so the toilets did not come directly off the lounge, which they described as "awful and undignified." They said they would ensure they were fitted with proper locks which could be easily accessed by staff in an emergency.

Staff checked with people if they required clothes protectors at lunch, although it appeared they had run out. After lunch one staff member ensured people had an opportunity to wipe their face if required. When asking people if they needed support for personal care, staff did this in a respectful and discreet way.

We saw in care files that people wanted to be encouraged to keep their independence, though heard one person say, "I think I could stand up more but I don't like to ask as they [staff] have so much to do." Staff were aware of making sure people had choice and how they needed to maximise their independence. One person said they would like more support to leave their room. When this was discussed as part of feedback, the provider and registered manager said this person was regularly assisted to come down for their meals, but once eaten always insisted on returning to their room.

Requires Improvement

Is the service responsive?

Our findings

People said staff were usually responsive to their needs. One person said they would like more support to come out of their room. Another said they had to wait long periods at times for their call bell to be answered. The provider was in the process of installing a new call bell system which would allow them to monitor how quickly calls bells were being answered.

A care worker came in on their days off to provide some stimulation and activities for people. This was popular and we observed people really enjoying playing bingo on one afternoon. The provider said they also had a paid entertainer come in up to three times a week to provide music sessions which people enjoyed. It was unclear how these activities had been decided, whether they had consulted with people about what they would like to do. People who were unable to leave their room had little or no stimulation apart from when care staff visited them to deliver care or food and drink. There were few opportunities for people to experience outdoor activities or visits to places of interest. One care worker said they had tried to organise an outing but had been told it could not go ahead due to insurance. We spoke at length with the registered manager and provider about how they planned to enhance the activities and provide more meaningful engagement for people throughout the day. At present this was very ad hoc and did not consider the needs and preferences of everyone. Most people spent their day sat in the main lounge, but we saw some people sat in their rooms and one person told us they were lonely and isolated and care staff did not have the time to stop and talk to them.

Care plans did not document people's histories so that new staff could learn about people before they started providing care. Care records showed needs were being reviewed but there was no evidence that this was done with people, family members or health professionals contributing. Care files we looked at did not contain the signatures of people to show they had taken a part in saying how their care plan should be written.

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

We saw evidence of some person-centred practice in the care plans and in how well care staff knew people. Care plans contained specific preferences such as "enjoys a glass of cold milk with ice" and "likes to listen to classical music in the morning." We saw these preferences being honoured in the care provided on the day with the person who liked the milk getting milk with ice and classical music being put on the radio

We had feedback from three visiting professionals who said the service could be more responsive, one professional said, "They need to be more responsive when professionals contact them." We were told of times when nobody answered the phones or responded to messages concerning the needs of people. The provider said they had addressed this by having a permanent administrator at the home. He said he and his family member were also having a more visible daily presence at the home to ensure phone calls were answered in a timely way and to work with staff on making improvements to people's care.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care plans included where staff needed to consider people's sensory or hearing impairment. Staff were able to communicate with, and understand most people's requests and changing moods as they were aware of people's known communication preferences. However, there were no communication aids being considered or used for people with dysphasia. Areas of the service were not well signposted with pictures, for example toilets, to help people find their way. The provider had purchased clear signage for fire exits since our inspection.

We recommend the service looks at best practice guidance for working with people with dysphasia to consider how best to support them to communicate their choices, such as use of photos and flashcards.

The registered manager said there had been no formal complaints since they took over the service in June. We were made aware of one family who removed their family member as they did not feel the provider was making improvements quickly enough. The service administrator had spent time talking with them and their concerns had been documented as well as what action had been put in place to resolve concerns raised. The complaints process was available to people, but may not have been in an accessible format for everyone.

People's end of life care had begun to be considered as part of care plans. Preciously this was an area the in-house nursing staff would have dealt with. The care staff would now call upon the community nursing team and GP for end of life care support for people.

Requires Improvement

Is the service well-led?

Our findings

The registered provider took over this service in June 2018. The service provided nursing care at this time. Shortly after taking over the then registered manager and most of the nursing team left. This meant the service was struggling to provide adequate nurse cover. The new provider made the decision to become a care home without nursing. They were in the process of applying to have the regulated activity associated with nursing removed from their registration.

The provider also had another home and the registered manager from this service applied to include this location as part of their registration. The provider and registered manager acknowledged that this was, in hindsight, too much for the registered manager to oversee. They have since appointed another manager who was due to start working at the service within a short time following this inspection. The registered manager will then return to their other service to manage this full time.

Some staff we spoke with were not fully aware of who the registered manager was, and different staff fed back there had been a lot of change and it had been confusing at times. They also said they did not feel valued or listened to. One staff member said, "There have been a lot of changes, some good, like improvements around the home, but some not so good, like the manager not always being around." The provider acknowledged that staff had gone through a number of changes which had impacted on them. They agreed better communication was needed, including more regular meetings and feedback to staff.

There was a lack of oversight regarding care records and documentation. Care documents were not always fully completed or were filled out incorrectly and this had not been identified before our visit. For example, for one person their medicines had not been administered as per instructions and this had not been picked up through gaps in records and care documents. Body maps had been left undated and types of skin issues had not been coded as per the instructions on the sheet. This showed care staff did not always have the knowledge to correctly fill out care records and it was not yet being picked up by an auditing process and remedied.

Some systems were in place to audit the environment, but these had failed to pick up on the issues we identified. These included one window restrictor not fitted, no checks on window restrictors, no regular checks on mattress settings and no oversight on what was missing from care plans, such as risk assessments in relation to bedrails. The registered manager and provider were responsive to feedback on the day of inspection, every time we raised a concern about the environment it was remedied straight away or action was taken to start the process of fixing it. However, their own oversight and quality monitoring required improvements to ensure it was robust and looked at all aspects of care delivery, records and environmental checks.

Accidents and incidents were recorded and checked by the registered manager. It was not always clear that this resulted in changes to practice, that learning was shared. For example, one incident recorded a person had got their leg caught in the bedrail and no protector was available. This did not alert the management team to be proactive to check and record that risk assessments were in place for each person where this

type of equipment was being used.

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

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not document people's histories so that care and support could be delivered in a person centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service had failed to assess people's capacity and act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always kept safe because the service had failed to mitigate risks in respect of the environment, risk assessments had not always been completed and improvements were needed in the management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not robust and failed to identify issues in respect of the environment, records and some aspects of care delivery.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment was not robust and did not protect people from the risk of staff who were not suitable to work with vulnerable people being employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient staff with the right skills to ensure people were kept safe and their needs were being met in a timely way.