Barchester Healthcare Homes Limited

Worplesdon View

Inspection report

Worplesdon Rd
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Surrey
GU3 3LQ

Tel: 01483238010

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on the 25 August 2017 and was unannounced. Worplesdon View is a purpose built care home providing nursing and residential care for up to 78 older people, some of whom were living with dementia. The service is separated into three units; one of the units is for people living with early to late dementia and the other two units are for people with greater nursing needs. At the time of our inspection there were 69 people were living at the service.

There was a registered manager in post and present on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were mixed responses from people and relatives about whether there were enough staff to support people. Our observations were that in some parts of the service there were not enough staff both at night and during the day and this put people at risk.

People's risks were not always been managed in a safe way including call bells being out of reach, accidents and incidents had not always been analysed. Risk assessments were not always in place. Other risks were being managed well including skin integrity and clinical risks.

We did find occasions where staff treated people in a caring, kind and considerate way. However there were also occasions where people were not treated respectfully or with dignity by staff.

Care plans for people did not always provide detailed guidance for staff on how best to support people. Staff did not always share detailed handover information about people's needs. We did see other care plans that were detailed around the guidance staff needed to provide care. People and relatives said that staff communicated well with them.

Although people and relatives said they knew how to complain, when they did complain this was not always resolved to their satisfaction. Complaints were not always being recorded in line with the provider's policy.

Medicines were being managed appropriately. We asked the registered manager to ensure that staff were recording when they had offered people 'as and when' medicines as there were some gaps around this on the medicine charts.

There were aspects to the competencies and skills of staff that required improvement. Health care conditions were not always being identified in a timely way and staff needed additional training to help support the needs of people living with dementia. Some staff were receiving one to one supervisions with their manager but clinical supervisions with nurses were required.

The environment where people lived with dementia required improvements and this was being undertaken by the provider.

There were mixed responses from people, relatives and staff about how well the service was being managed. Staff had differing opinions about whether they felt supported, valued and listened to.

There was a lack of leadership in some parts of the service. Systems and processes were not established and operated effectively to make improvements. Records were not always accurate or kept securely.

Notifications that were required to be sent to the CQC were not always being completed including safeguarding concerns and notifiable injuries.

People told us that they felt safe with staff and were not concerned about how they may be treated. Relatives also felt their family members were safe with staff. Staff understood what they needed to do if they suspected abuse and who to report it to. Staff employed at the service underwent robust recruitment before they started work.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005 (MCA). We noted that DoLs applications had been completed in line with current legislation to the local authority for people living at the home.

People enjoyed the food at the service and people's hydration and nutrition needs were being met. We did recommend that people that were on modified diets were also offered a choice of meals. People told us that they were able to access health care professionals when they needed.

People and their relatives told us that activities took place at the service. People had access to activities that were important and relevant to them. People were protected from social isolation and there were a range of activities available.

During the inspection we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of 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.

There were not enough staff at the service to support people's needs in parts of the service. In other parts people's needs were being met promptly.

People were not always protected from risks in a consistent way.

Medicines were administered, stored and disposed of safely. Improvements were required to ensure that MAR charts were always completed in relation to 'as and when' medicines.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff that had the necessary skills and
knowledge to meet their assessed need.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk. However people were not always offered choices around meals. We have made a recommendation regarding this.

Staff understood how to apply legislation that supported people to consent to treatment. Where restrictions were in place this was in line with appropriate guidelines.

People had access to healthcare services and healthcare professionals were involved in the regular monitoring of their health.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with dignity and respect. However we did see occasions where staff were kind and attentive.

People's preferences, likes and dislikes had not always been taken into consideration and support was not always provided in accordance with people's wishes.

People's relatives and friends were able to visit when they wished.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always have detailed information regarding people's treatment, care and support.

People were encouraged to voice their concerns or complaints about the service however people and relatives did not always feel their complaints were responded to. Complaints were not always recorded.

People had access to activities that were important and relevant to them. People were protected from social isolation and there were a range of activities available within the service and outside.

Is the service well-led?

Inadequate

The service was not well- led.

The provider did not always have systems in place to regularly assess and
monitor the quality of the service the service provided.

The provider had not always actively sought, encouraged and supported people's involvement in the improvement of the service.

People, relatives and staff did not all feel the service was managed well.

Staff were not always encouraged to contribute to the improvement of the service and staff did not always feel they

could report their concerns to their manager.

Notifications that were required to be sent to the CQC were not being done.

Worplesdon View

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 was an unannounced inspection which took place on 25 August 2017 in relation to concerns that had been raised. The inspection team consisted of four inspectors. We arrived at the service at 06.30 as we had received concerns that there were not sufficient staff at the service, that people were being woken earlier than they wanted and that people's needs were not being met in a safe way.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. On this occasion the Provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Instead we reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law. We also spoke with one social care professional before the inspection.

During the visit we spoke with the registered manager, the regional manager, eight people, seven relatives, 11 members of staff and one health care professional. We looked at a sample of seven care records of people who used the service, medicine administration records and supervision and one to one records for staff. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service. After the inspection we spoke with three health care professionals.

The last inspection was in November 2016 where no breaches of regulations were identified.

Requires Improvement

Is the service safe?

Our findings

There was a mixed response from people and relatives about whether there were enough staff at the service. Those that felt there were enough staff told us, "There are plenty of staff here. When I use my call bell they always come quickly", "When I ring my bell they usually come in good time". Relatives told us, "I tend to visit in the mornings and there always seems to be enough staff then. I cannot comment on the afternoons. When my (family member) had a fall yesterday the staff came very quickly to her", "I think there are enough staff for my (family member), they always appear to be around" and "There is nearly enough staff around, occasionally it can be difficult to find a member of staff."

Comments from people and relatives who felt there was a lack of staff included, "Staff seem to be very pushed; there are a lot of people living here. Staff cannot be everywhere at once. Staff rush with my care and they have no time to talk to me", "Staff are always busy, they have been short of night staff", "I don't think there are enough staff on the top floor, there is one nurse and four carers in the morning and a nurse and three carers in the afternoon. They stopped a host (member of staff to support with meals) from helping at meal times and this meant that staff had to dish up the food as well as helping people to eat", "I don't think they have enough staff on the top floor."

This was reflective of our findings on the day of the inspection. In some areas of the service the staffing levels were sufficient. However in other parts of the service there were insufficient staff to meet people's needs at night and during the day. On the floor where people lived with dementia there were two night carers on duty at 06.30. Those people that were up and dressed were either walking around the service or sat in the dining room. They did not have support from staff as staff were busy providing care to people in their rooms which put these people at risk.

On the first floor there needed to be two night care staff and one nurse. However a member of care staff had called in sick. This meant that one care staff had been left alone at 06.45 on the floor to care for 25 people as the nurse had gone to administer medicines on another floor. The member of care staff was busy trying to care for one person who rang their bell frequently and required attention. The staff member said to their colleague at 07.30 who came to assist "It's not good enough". We asked what they meant and they replied, "I should not have been left on my own, I know that nurse is agency but she should have known not to leave me alone". A staff member said when asked if there were enough staff at night told us, "It is very difficult and stressful." We spoke to the registered manager about the lack of staff on the first floor and they told us, "One staff member to 20 people is okay in the sense that it's a well organised unit. Come 11.00pm there is barely anything to do. It's never been unsafe." We found that these were not safe levels based on our observations and the potential risks to people.

During the day on the floor where people lived with dementia morning personal care was still continuing for people at 12.00. One member of staff said, "There are supposed to be five care staff and one nurse for the morning but it's just not enough, especially with people that have such high needs. There are short cuts with care. One to one activities are lacking. We aren't able to prompt people enough to go to the toilet. We do get quite a few falls especially when we are short staffed." We noted that in addition to the nurse only three care

staff were on duty in the morning on the day of the inspection and one new member of staff that was on their induction. Another member of staff said, "Five care staff just isn't enough. We have 18 people to support to eat and 15 people that require hoisting to move. People are being neglected. We don't have enough time for people. Sometimes people stay in bed later because we haven't got time to get them up sooner."

On the ground floor one relative told us that their family member needed support to help them drink medicine for a health condition. They said this was not happening as staff were too busy to take time to sit with their family member and encourage them to take it. Staff spoken to on this floor also confirmed that on occasions there were only two care staff on duty on the ground floor and they did not always get time to read people's care plans. We observed that staff were busy and task focused which meant that they did not always have time to spend with people. The agency nurse told us that there could be additional staff to help at busy times.

During lunch on the top floor three members of staff were providing one to one support to people to eat. However, we noted that two people had to wait a long time before they were served and supported with their lunch. One person waited until 13:05 before staff were able to serve and help them on a one to one basis. Another person waited until 13:08 before having their meal. Both people had been in the dining room sat at the table since 12:15.

The registered manager told us that they used a service dependency tool to help determine the numbers of staff needed. The rotas showed that more often than not the numbers they assessed were needed were met. However the staff we spoke with felt the tool used was not accurately assessing the correct levels of staff needed. One member of staff said, "I have my opinion of (the dependency tool). We need to roter on more staff upstairs (the floor where people lived with dementia)." Three health care professionals told us that when they visited they felt there were not enough staff on the floor where people lived with dementia.

On the first floor the day staff felt that there were sufficient staff and that people received the care they needed when they needed it. One member of staff said, "It is four carers today but it can go up to five or six, this includes a team leader and there is a nurse as well". We observed that people received care when they needed it.

As there were a lack of staff to support people's needs this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an inconsistent approach to the management of risk. One person had a sensor mat in their room to alert staff when they got out of their chair or bed. This person had fallen in their room on three occasions in the last three weeks and had sustained an injury on the last fall which had required hospitalisation. A falls diary had been completed but this did not have the last fall recorded. The person's risk of falling had been reviewed but had not been updated to reflect the latest level of risk. We spoke to the registered manager who said this should have been completed. They told us they would ensure this was updated and staff informed of the change. Another person was staying for respite did not have a falls risk assessment completed despite their notes recording that they had nearly had a fall since they had moved into the home.

During the inspection there were occasions where people (who were able to use them) did not have access to their call bell. Three people's call bells were pulled out so that they could not be used. One person called out to us as they could not locate their call bell. Their call bell had been hung behind their bed out of reach. They asked us, "How am I supposed to reach back there." They told us that they had been trying to get the

attention of staff for some time. Another person told us, "I cannot reach my call bell at the moment." The call bell was under some clothing on an armchair and the person was lying on their bed. Another person had been left alone with a drink despite their care plan stating that they were at high risk of choking and needed support to drink.

The accidents and incidents folder contained a high number of unwitnessed falls and incidents; this demonstrated that staff numbers were not high enough to ensure that people were kept safe. Over a six six-week period there had been 12 unwitnessed incidents on the dementia floor, 10 on the ground floor and seven on the first floor. Accidents and incidents were not always responded to appropriately. Incidents were documented but actions taken to prevent an incident happening again were not always recorded. There was not always evidence of what actions were taken to reduce the risks to people.

As care and treatment was not always provided in a safe way this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people were identified and assessments completed to help keep people safe. One person was at high risk of malnutrition and needed to have a soft diet due to swallowing difficulties. There was a choking risk assessment in their care plan and we saw that specialist input had been provided by healthcare professionals. Another person was at risk of developing pressure sores and needed a mattress to help prevent this happening. We saw that this was being used and the mattress was on the correct setting for the person's weight. There were people that had call bells in reach and for those that were up and awake early in the morning they had pendants round their necks which they could use. In the event of an emergency such as a fire each person had a personal evacuation plan and staff understood how to evacuate people in an emergency.

People told us that they were happy with the way their medicines were managed by staff. A relative said, "The staff always come and give (the family member) her medicines on time. They know to give her pain killers as the staff here have said how important it is that she remains pain free. One person said, "Yes they are good, I always get my medicines on time and I know what they are for". Each person had an individual medicines profile that contained information about the medicines they took, any medicines to which they were allergic and personalised guidelines about how they received their medicines. There were PRN (as and when required) medicine guidelines for staff with details of what signs the person may show should they need pain relief. We did raise with the registered manager that staff were not always recording whether people had been offered PRN (as and when required) medicines. After the inspection the provider informed us that they had addressed this with staff. We will check this at the next inspection.

People told us that they felt safe with staff. Comments included, "I feel safe. Staff look after me well. They are always nice and polite"; "Staff are very good here. Staff always treat me nicely, I have never been shouted at." Relatives we spoke with also felt their family members were safe. Comments included, "My (family member) is 94 years old and is mobile. She is safe here and has never been mistreated. The corridors are clean and always lit. She has never been shouted at", "My (family member) felt unsafe when they were in hospital, but feels safe here. Staff made her feel so welcomed, she has never been mistreated", "Staff had knowledge of safeguarding adults procedures, the types of abuse that could occur and what to do if they suspected any type of abuse. There was a safeguarding adults policy and staff had received training in safeguarding people.

People were protected from being cared for by unsuitable staff because robust recruitment was in place. Staff told us about the selection procedure that they went through to ensure that they were safe to start work. Staff told us that they were interviewed for the job and had to provide two references and had to

undergo DBS checks. All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms had been fully completed; with any gaps in employment explained. The provider had ensured that staff had the right to work in the country and screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

Requires Improvement

Is the service effective?

Our findings

Staff were not always competent, skilled and experienced to meet the needs of people. There were mixed responses to whether people and relatives felt staff were competent in their role. Relatives told us that the nursing and care staff were not always proactive when it came to addressing their family member's medical conditions. One person had recurrent urinary infections, their relative told us they noticed their family member was not their usual self and had to ask nursing staff to arrange a urine test which identified the person had an infection. Another relative told us their loved one needed cream applied to prevent a medical condition occurring but this had not been done which had led to them having to have medical treatment.

Nurses had not received the appropriate support that promoted their professional development. We asked to look at the clinical supervisions that the clinical lead (who had recently left) had undertaken with the nurses. We were provided with some evidence of one to one discussion but these centred mainly on feedback discussions about general concerns with the registered manager about medicines management. The registered manager told us that clinical supervisions had not been taking place. Other staff had received one to one supervisions with their manager. We asked the registered manager to provide a matrix of supervisions that had taken place but to date we have not received this.

Staff told us they felt supported although had not always received training specific to the role they were working in. One member of staff was completing their induction and told us they spent three days at a different home getting training in manual handling, fire safety and other relevant areas. However they had not received dementia training which they told us would be useful to them. We noted that there was another new member of staff who was supposed to be shadowing other staff and had only worked at the service for two days. We saw that the member of staff was providing support to people despite not knowing or understanding what their needs were. Two health care professionals told us that they had concerns that staff did not always understand the needs of people living with dementia. We saw that staff had undertaken the service mandatory training but this did not include dementia training or training around behaviours that may be challenging.

As staff were not always receiving the appropriate training and supervision to undertake their role and staff were not always competent and skilled this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other relatives that we spoke to said that staff appeared confident and had no concerns about their competency. One relative said their loved one was moved using a hoist, they told us staff were calm and caring when they undertook this. We did observe some good practice by staff on the day particularly in relation to how people were moved, infection control and food hygiene.

The environment did not always meet the individual needs of people living at the service living with dementia. There were not always memory boxes outside people's rooms to help orientate them. There were people walking around but there were no particular areas of interest or sensory items to keep them occupied or engaged. We did see that there was signage on the doors to help guide people if they needed to

use the bathroom. The lounge areas were well lit and people were able to walk around where they wanted. The registered manager told us that they had intentions to improve the environment for people living with dementia through a '1066' project specific to supporting the needs of people living with dementia.

People told us that they enjoyed the food at the service. Comments included, "The food is very good, I cannot complain about the food", "The food is superb; there is always a choice of meals", "The food is very, very good, there is always a choice of two meals"; "There is always a good choice of food."

We observed lunch being served in the dining rooms in each unit. People were asked what they wanted or offered a visual choice if this was easier for people to make a decision. However one member of staff told us that people who were on soft or pureed meals were not offered a choice of a meal. For those people that needed it equipment was provided to help them eat and drink independently. Nutritional assessments were carried out as part of the initial assessments when people moved into the service. These showed if people had specialist dietary needs. People's weights were recorded and where needed advice was sought from the relevant health care professional.

We recommend that people who require the consistency of their food to be modified are offered a choice of nutritious food.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005 (MCA). 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. We saw MCA assessments had been completed where people were unable to make decisions for themselves. Best interest meetings took place with the appropriate health care professionals present when needed. The assessments were specific to the decision that needed to be made for example in relation to bed rails or being under constant supervision. Staff were able to describe MCA to us and told us that they needed to assume that people had capacity in the first instance.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).We noted that DoLs applications had been completed in line with current legislation to the local authority for people living at the home.

Other people that we spoke with told us that they were able to access health care when they needed. Comments from people included, "I have only been here three weeks but I know the GP visits to have a surgery every week. I have not yet had the need to see any healthcare professionals", "I see all the people I need to like the doctor and hospital appointments. I have been able to keep my own doctor", "I see the healthcare professionals and this includes the community health nurse", "I go to my own dentist. The doctor comes here every Tuesday and I can see him if I need to. The doctor is from my own surgery." We saw from notes that GP's, dentists, chiropodists and Tissue Viability nurses saw people as needed and their advice had been recorded. In one care plan it was clear that nurses had followed the doctor's advice and the person had recovered.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity. When we arrived at the service there were people that staff told us had received personal care. Those people were unable to tell us whether this personal care had taken place. Staff told us that one person had received a full body wash and that this took place in the person's bathroom. However the sink and bowl in the person's bathroom had not been used. The person's toothbrush had not been used despite it stating in the person's care plan that their teeth needed to be brushed every morning after their wash. One member of day staff told us that they had been told by the night staff that a person had already been washed. However they told us that food still remained on the person's face from the meal the night before. A member of staff told us that they had showered another person but that they had forgotten to brush the person's teeth when we asked why the person's toothbrush was dry. Two relatives told us that staff did not always maintain good dental hygiene for their family members.

The registered manager told us that personal care tick boxes needed to be completed by staff to identify what care people had received. We identified that staff were not always completing these. The registered manager said that they would expect staff to always fill them in to show when care was given. We could not identify if people had regular baths or showers, whether their incontinence needs had been attended to, whether they had help with their oral care particularly for those people that were unable to communicate whether this had been done.

People were not always treated respectfully by staff. We saw several occasions when staff entered people's rooms without knocking on doors. On one of the floors, whilst people were eating their breakfast, one member of staff was organising cutlery by putting this into trays. This went on for several minutes and the noise from this was considerable. No consideration was given to people who were eating their breakfast. One member of staff brought a person into the dining area in a wheelchair and asked another member of staff, "Where do I put this one?" in reference to the person they had just brought in. We noticed when we arrived on one floor at 06.30 that the curtains were open in three people's rooms and the lights were on despite the fact that these people were asleep. When we asked the night staff why curtains were open they told us that this was in readiness for providing personal care to them. This indicated that these people were being woken up without choice.

There were times where people were not treated in a caring way. One person who needed support to drink had been seated in the dining area for over 90 minutes before they were given a drink. We had spoken to a senior member of staff about this who acknowledged they had been waiting for a drink but they did not ensure one was provided. It was not until there had been a change of staff that this person was provided a drink and a further 20 minutes before staff spent time supporting them. On another occasion we heard a person ask two members of staff, who were supporting them to get up, "Where am I? Can you tell me where I am?" Neither member of staff answered the person. The person told staff that they were, "Gasping for a cup of tea." When a member of staff took them to the dining room they did not get the person a cup of tea for another 15 minutes despite the person saying, "Come on please. Where's the tea. Come on please, please." One relative told us they had, on occasions, heard staff speaking, "Sharply" to people. They acknowledged

that the staff did a difficult job but told us they did not think it was appropriate for staff to speak this way.

One person called out to us and told us that they were very anxious and wanted to get out of bed. They did not want us to leave the room as they were so anxious. We asked staff if they could offer the person some support and asked how they would reassure the person. Staff just asked the person if they wanted a cup of tea. No steps were taken by the staff to offer support or reassure the person. Later in the morning one person had been left in the lounge and Christmas Carols were playing on the CD player which was next to them. The person was living with dementia and thought had not been given by staff that playing Christmas Carols in August could cause confusion. A member of staff later came in and changed the CD to something more appropriate.

As people were not always treated in a caring, dignified and respectful way this is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This treatment of people we have identified was not reflective of all the care across the service. There were staff that were kind, caring and attentive to people's needs. There were people and relatives at the service that felt that staff were caring. Comments from people included, "They (staff) are very kind here, and they always do what I want", "I like it very much", "The girls are so kind and caring, nothing is too much trouble." We observed one person asking where their room was and a member of staff stopped what they were doing and assisted the person back to their room.

People told us that staff respected their privacy and dignity and that staff encouraged them to be as independent as they were able. One person said, "Oh, staff do respect me. They call me by my name and they always knock on my door." Another person said, "Staff are very caring and they do my personal care in the privacy of my bedroom with the door closed." A third person said, "I do things for myself, staff will help me if I need it." A fourth said, "Staff always ask me if I am ready for help with my bath or shower if I choose to have a shower. They close the doors when helping me."

We did see a member of staff support a person back to the room to provide the personal care that they needed and ensured that the door was closed. Staff who supported people on a one to one basis sought people's permission before they commenced. Throughout the rest of the day we saw staff knock on doors and wait before they entered. One relative told us that staff always used a dignity screen when they hoisted their loved one.

One person was coming towards the end of their life. Relatives told us the person was comfortable and the staff were very good. They said, "The staff are lovely here, I cannot fault it. They always pop in to make sure (their family member) is alright. I stayed over and can stay any time and I am always offered food and drinks or I can help myself. The Macmillan nurses come in a few time as well. It was (their family members) birthday and staff all came in and had baked a cake. Another relative told us that staff were good at helping their family member to stay well-groomed. They said, "They always help her with her mouth care and do her hair".

We observed staff interacting with people in a caring and supportive way. Staff always spoke to the person when supporting them. For example, one person was being supported to the dining room and used a walking aid. The member of staff reassured the person they were going in the right direction and supported them to find a table they wanted to sit at. During lunch staff offered people a choice of soft drink and explained to them what the choice of meals were. One person asked what the tiramisu was; a member of staff explained that it was a dessert and it tasted a bit like coffee. Staff checked on people throughout the meal, asking what their meal was like and if they were enjoying it. For example, a member of staff asked a

person, "What is your fish like today?" They responded by saying it was very nice. We saw one member of staff stoop down to the person's level and listening to them and responding with kindness. Another person needed help when they walked was supported by staff who walked with them and encouraged them. They explained where they were going and once the person had sat down they got them a cup of tea.

One person coming towards the end of their life received communion every week which their relative said was important to them. Another person said they still go to church with their friend who also lives in the home. They said people from church come to collect them but they had been told that more frequent services were going to be arranged in the home too.

People were able to personalise their room with their own furniture and personal items so that they were surrounded by things that were familiar to them. People told us that they were encouraged to bring things into the service that were important to them. Each room was homely and individual to the people who lived there. Relatives and friends were encouraged to visit and maintain relationships with people. We saw visitors welcomed throughout the day of the inspection.

Requires Improvement

Is the service responsive?

Our findings

People's care plans did not always accurately reflect the care they needed or were provided with. We saw that two people needed to have their blood monitored daily as they were diabetic. Their care plan did not provide the information that staff needed to advise them of the signs to look for if their blood sugar levels were too high or too low. Another person had epilepsy and the guidance in the persons care plan was not clear in relation to what staff needed to do if the person had a seizure. The terminology used was clinical and the nurse on duty who we spoke to about this did not have a clear understanding of the guidance.

Where detailed guidance was provided to staff about how best to support people this was not always followed. For example, one person's care plan stated, 'Care staff to ensure she sits on a suitable chair for her height and that the chair has handles.' The person had been positioned on a sofa, sloped backwards with no handle on their left side to support the person to sit up or stand up if they wanted. For one person who was staying at the service on respite there was limited information in their care plan to help guide staff about the most appropriate care.

We observed handover on the top floor where people lived with dementia. The handover was conducted with a nurse coming on duty and a member of care staff going off duty. The only information that was being shared was around whether people had received personal care and whether the people had had a settled night. The information shared about who had received personal care was not always accurate. There was no discussion about people's clinical care. The member of staff going off duty had not shared with the team coming on duty that one person had been particularly anxious with them. This was the person that had insisted on us staying in their room with them.

Care and treatment was not always provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see other care plans that were detailed around the guidance staff needed to provide care. For example, one person was at the end of their life. There were detailed instructions concerning how the person needed to be care for and staff were following this guidance. Other people's care plans had a description of people's medical history, moving and handling, skin care and sleep routine and how people needed and wanted to be supported.

During handover on the first floor the nurse gave a briefing on how people had been overnight. The team leader then directed the care staff in what to do. They also reminded staff to check people's skin and report any redness. Staff were told people's mobility needs and who needed help to move position in bed.

Relatives that we spoke with told us that staff communicated well with them. One told us, "I have been very pleased; the staff talk to me all the time and respond to my mother. They don't just support her but the family as well." Another relative told us that an assessment of their family members needs was undertaken in hospital. They told us that when their family members' needs had changed they discussed this with them which they appreciated. Relatives told us they had been involved with their family members care plans and

had attended reviews. Comments from relatives included, "I have been involved in her care plan and they are reviewed every month" and "I have discussed the care plan with my mother and told her she could make changes to it if she wanted to. I can also make changes to it if I thought it was necessary."

People said they knew how to complain. We saw a complaints procedure in the main reception area. One person said, "Yes I would just speak to the staff and I know they would do something." Another person said, "I can complain but I haven't needed to". One relative said, "I have spoken to staff about little things and they have sorted it out straight away. However another relative said, "There is one little thing, I have raised about (their family members) dentures they haven't been cleaned and I have said it twice, I now have to add steradent to her dentures when I visit." Two relatives told us that they had raised concerns with the registered manager about the standard of care their loved ones received. They told us the registered manager had listened to their complaints and tried to resolve them but this had not been successful. One relative told us they felt nervous about making a formal complaint as they felt it might affect the care their loved one received from staff. We checked the complaints records and found that these concerns had not been recorded however the registered manager was aware of them.

We saw that one formal complaint had been recorded since the last inspection and this had been responded to according to the complaints policy. The registered manager had not been keeping a record of verbal complaints or how these had been dealt with. They said they would start to do so. The service policy states that concerns and complaints can be raised verbally and that 'Regardless of how the complaint is expressed it must be treated seriously, logged and responded to.' However we found that this was not always being done.

As complaints were not always investigated and recorded with the necessary action taken this is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that activities took place at the service. On the day of the inspection we observed a music activity taking place that also included singing and dancing. The relative of one person who was being cared for in bed told us that the hairdresser does their hair and they have a pedicure every week as their family member liked to look nice. The relative was very appreciative of this. People said there was enough happening to keep them busy. One person said, "I find plenty to do, I join in, there's things going on." There was a notice board advertising activities including a trip out, a monthly cream tea and PAT dog visits. We saw a group of 12 people doing a crossword guided by staff in the main reception area in the late morning. On the floor where people lived with dementia ball games were being played and we saw that people were involved in this activity. One person asked a member of staff if they could go in the garden, the member of staff responded well and arranged for someone to take them into the garden which they did. Themed events including the summer fete and Christmas events also took place at the service.

Inadequate

Is the service well-led?

Our findings

There were relatives who felt the service required improvements with how the service was managed. One told us, "If the manager does not like you she doesn't want you (in reference to how they felt staff were managed.) Another told us, "Communication is not good from the manager. I have heard the manager telling staff 'If you do not like working here then go and work for (another provider)." A third told us they had complained about care being provided and in their opinion the registered manager was "Finding it difficult to get this across to staff."

People and relatives were not given the opportunity to attend meetings to discuss the running of the service. One relative told us, "Communication from the manager is bad, no relatives meetings. I don't know what is going here. The manager says we could always ask her but this is not always feasible, for example, we are not told when new staff start." Another told us, "She (the registered manager) stopped the resident and relatives meetings." A third said the resident and relatives meetings were stopped by the registered manager as this was, "Not her style." A fourth told us that the only thing that concerned them was that, "The relative and residents meetings have been stopped." The registered manager told us that they had stopped the residents and relatives meetings because they did not find that they were effective.

The culture of staff within the service was divided between those that felt the service was managed well and those that felt that they were not listened to or valued. Positives comments from staff included, "I feel the home is managed well. I could not ask for a better manager", "I feel supported by the manager." Other comments from staff about how supported they felt included, "I know the manager tries to get staff in but then we are told we have enough staff", "(The registered manager) is not supportive. She doesn't come to this floor and check what's going in here"; "The manager rarely helps out. Things have gone downhill."

Staff were not always given opportunities to have input into the running of the service. We saw that staff meetings took place and that these were used as an opportunity to remind staff about policies, training opportunities and areas of care that required improvement. However we noted that staff were reminded not to 'Chit chat' and where staff had a concern to only disclose this on a one to one discussion with their manager. Staff were not being encouraged to discuss their views openly at meetings. We also noted that at a team meeting in July 2017 staff were being reminded to complete food and fluid charts and improvements were required with people's dental hygiene. These are areas that we had identified that still required improvement.

We found that there was a lack of leadership on the floor where people were living with dementia. On the day of the inspection we identified that there was no senior on duty at night having oversight of how staff were performing. One member of staff said, "Leadership is a concern on the upper floor." Another member of staff said, "We have no unit manager and we need that." Staff told us that they did not always feel that they could raise their concerns. One told us, "I am very stressed. When you speak up there is no solution." Another told us, "Staff feel as though they can't speak out."

Records at the service were not always kept up and date, accurate and secure. There was a risk that staff did

not have the most up to date information about people's care needs. For example one care plan stated that the person needed to wear hearing aids and to ensure that these were in place each day. When we questioned this with staff (as the person was not wearing them) they told us that the person no longer used them as they refused to. Their care plan also stated that staff needed to ensure that the call bell was in reach for the person however the person was unable to use a call bell. People's food and fluids charts were not always being completed. It was not clear if people were having sufficient amounts of food and drink where it had been identified that this needed to be monitored. According to five care plans people's food and fluid needed to be recorded however this was not being done. Where food and fluid charts were completed by staff there were no total goal amount so staff could not see if a person was having the right amounts.

Where people required repositioning (to reduce the risk of pressure sores) staff had recorded on ten people's records that all of them were re-positioned at the same time. As all required two members of staff and there were only two staff on duty it would not have been possible for this to have happened at the same time. We noted in one person's care plan that they had a wound on their leg. However the photo of the wound was not dated and the measurements of the wound were out of focus so it was not clear what size it was. We spoke with the nurse who told us that they would address this. Personal care charts were not being fully completed so we were unable to tell if people had received the care they needed.

Records were not always kept securely. When we arrived at the service we noticed that the nurse's station (where people's care plans were kept) and the medicine room on one floor had been left unlocked. We raised this with the nurse on duty who told us that they would address this. However when they returned the trolley to the medicine room they left the rooms unlocked again and then returned to the floor they were based on. We found that some care records were illegible due to the poor handwriting.

There were aspects to the quality assurance that were not always effective. We were provided with copies of the providers audits that had taken place in January 2017 and April 2017. Concerns identified included the lack of actions recorded in relation to accidents and incidents, the lack of monthly residents meetings and the inconsistent completing of food and fluid charts. These concerns had been identified by us on the inspection and had still not been addressed. The night visit checks undertaken by the registered manager were not detailed and did not highlight the lack of food and fluid recording. On a night check in July 2017 it stated that (in relation to Food and Fluid records) 'All up to date and totalled' however from our checks we identified that this was not the case.

Where concerns from night checks had been identified it was not clear from the audit which unit the concerns related to. For example in July 2017 it had been identified that one member of staff had their eyes closed. The action stated, 'Requested to open eyes. Will arrange a supervision and make clear the expectation.' This suggested that a member of staff may have been asleep but the record did not state what unit this related to or if this had been followed up. On another occasion in April 2017 a night check record stated that MAR sheets had been checked and the action was, 'Reminded nurses to compete PRN charts.' There was no detail in relation to what was the concern was in relation to PRN charts. A medicine audit in August 2017 had identified gaps in recording on the MAR charts however when we inspected there were still gaps where staff had not stated whether PRN medicines were being offered. It had also been identified that care plans for people that were diabetic needed to be updated however this was still a concern on the inspection.

Where the registered manager had opportunities to work with outside agencies to improve the quality of care for people this was not always being taken up.

We found seven breaches of the Health and Social Act 2008 which impacted the care that people received

across all the key questions we asked. These areas required improvement which should have been identified by effective management oversight.

As systems and processes were not established and operated effectively and records were not always accurate or kept securely this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in November 2016 we had identified that notifications had not always been sent to the Care Quality Commission (CQC). Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager told us at the previous inspection in 2016 that they would ensure that this would be addressed. However on this inspection we found that not all notifications were being submitted to the CQC despite the requirement to do so. For example we were told that the service was closed for 10 days in February 2017 due to an outbreak of diarrhoea and vomiting. The registered manager had not informed us of this. There had been instances of injuries and alleged safeguarding concerns that also had not been notified to the CQC. This meant that we would not be able to adequately monitor how the service was performing.

As notification were not always been sent in to the CQC this is a breach of regulation 18 of the (Registration) Regulations 2009.

Other people and relatives we spoke with about how well they thought they service was managed. One relative described the registered manager as, "Very good. Outstanding". Other comments included, "I often see the manager and I can talk to her when I want to", "I know who the new manager is and there have been a lot of changes recently", "I think the home is well managed. I see the manager often", "I think the home has been better managed recently, the manager is always around" and "The manager has an open door policy and I can go to her at any time."

We saw various other audits that were being used to improve the quality of care. For example the cleanliness of the dementia unit had been identified as a concern as we saw that this had been addressed. PRN protocols were required to be updated and we saw that this had been undertaken by staff. Medicine audits had identified that the medicine room in one unit needed to be tidied and medicine policies to be kept in the MAR charts and we saw that this had been done.

After the inspection the regional manager provided us with a plan to detail what actions had and were going to be taken to address the shortfalls at the service. The plan addressed the staffing shortfalls on the dementia unit where they advised that they had now put in additional staff during the day and a nurse to manage the floor at night. They also advised that food and fluid charts and accidents were going to be monitored more closely. Clinical supervisions were going to be undertaken with nursing staff and contact was going to be made with health care professionals to request support and advice in relation to the needs of people living with dementia. The provider also advised that additional management support was going to be put in place to increase the oversight in the service. We will review these improvements at our next inspection.

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
Treatment of disease, disorder or injury	The provider had not ensured that care and treatment was always provided that met people's individual and most current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had not ensured that people were always treated in a caring, dignified and respectful way

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured that care and treatment was not always provided in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The provider had not ensured that complaints were always investigated and recorded with the necessary action taken

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider had not ensured that notifications were sent in to the CQC.

The enforcement action we took:

We have issued a fixed penalty notice in relation to this breach of regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured that systems and processes were established and operated effectively and records were not always accurate or kept securely.

The enforcement action we took:

We issued a warning notice in relation to this breach of regulation.