Lifeline Nursing Services Limited

St Edmunds Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected St Edmund's Nursing Home on 4 October 2016. This was an unannounced inspection. The home provides care and support for up to 49 people. When we undertook our inspection there were 42 people living at the home.

People living at the home were of mixed ages. Some people required more assistance either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks, with some having loss of memory.

There was a registered manager in post. 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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect them. At the time of our inspection there was no one subject to such an authorisation.

We found that there was insufficient staff to meet the needs of people using the service. The provider had not taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

We found that people's health care needs were assessed, and care planned and delivered through the use of a care plan. People were not involved in the planning of their care and had not agreed to the care provided. Some family members were involved in the care planning process, but this was a small number. The information and guidance provided to staff in the care plans was not always clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe. Staff did not always follow the advice in the care plans through to daily charts and observations.

People were treated with kindness and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

Staff had taken care in finding out what people wanted from their lives and had supported them in their choices. They had used family and friends as guides to obtain information. People who preferred to stay in their bedrooms were not offered one to one activities due to staff shortages.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or

people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it. People told us meals were sometimes bland and they had no menus to refer to each day prior to their meals. Staff did not ask people if they would like protective clothing when eating their meals, but assumed they would want to wear plastic apron bibs.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the home, however their views were not always taken into consideration when planning staffing levels, refurbishment of the environment and equipment needs. Quality checks had been completed to test whether services were meeting people's requirements. These were not always effective as there was no system in place to ensue staff were following people's needs, understood the training they had undertaken and ensured equipment and the environment was safe to live and work in.

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 consistently safe.

Checks were made to ensure the home was a safe place to live.

Insufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were stored and administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing. Menus were not available to remind people of the choices of food they had requested each day.

Staff did not receive all the suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Requires Improvement

The service was caring.

People were relaxed in the company of staff and told us staff were approachable.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The majority of people were not involved in the care planning process, but some family members had been asked their opinion.

Activities were planned into each day and people told us how staff helped them spend their time. However, there was no opportunity for staff to interact on a one to one basis with people, especially those who preferred to stay in their bedrooms.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Requires Improvement

The service was well-led.

Audits were undertaken to measure the delivery of care, treatment and support given to people.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

The views of visitors were sought on a regular basis.

St Edmunds Nursing 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 4 October 2016 and was unannounced.

The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection, we asked the provider 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. They returned the PIR and we took this into account when we made the judgements in this report.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority and NHS who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We spoke to a health professional during the site visit and two health and social care professionals before the visit.

During our inspection, we spoke with six people who lived at the service, four relatives, three members of the care staff, two trained nurse, a housekeeper, an activities organiser, a cook, and the deputy manager. The registered manager was not available that day. We also observed how care and support was provided to people.

We looked at eight people's care plan records and other records related to the running of and the quality of

the service. Records included maintenance records, staff files, minutes of meetings and audit reports the registered manager had completed about the services provided.

Requires Improvement

Is the service safe?

Our findings

People we spoke with voiced concerns over staffing levels and the impact this made on their care needs. This was more so for people who had mobility problems. One person said, "They're always short staffed here, at the changeover in the afternoon especially. They say they can't help at the moment as they're in a meeting." Another person said, "I can always find someone when I need them, but then I'm lucky being able to walk around." A relative told us, "The other weekend the nurse said they were very short. Don't' get me going on call bells." We questioned the person further and they told us when the visited their family member and the relative pressed the call bell, staff usually took a long time to answer.

Staff told us that the staffing levels were not good at times. One staff member said, "It can be stressful, if people don't' turn up." Another staff member told us, "If they all pitch in, if everyone turns up its ok. Weekend staffing is a problem, we do try and fill the vacancies, but if not we help each other out." Staff told us they could voice their opinions about staffing levels. They recognised that due to vacancies and a lack of professionally trained nurses in the area this was a problem. One staff member said, "Staff are working together."

The deputy manager told us how the staffing levels had been calculated, which depended on people's needs and daily requirements. These appeared to change weekly. The total staff hours required were completed on a weekly basis by the registered manager or deputy manager and submitted to head office. We saw the calculations for the weeks from 4 July 2016 to 26 September 2016. However, this did not give a complete picture of the staff required to directly look after people. Staff could not explain how they assessed whether there were sufficient staff to look after people. The deputy manager had told us they were supernumnery and would work alongside of staff if there were staff shortages.There were limited contingency plans in place for short term staff absences such as sickness and holidays, only the use of agency staff. Staff told us that sometimes the agency could not find staff due to demand in other areas. The staff rotas from 1 August 2016 to 28 August 2016 and the rotas from 26 September 2016 to 2 October 2016 showed lots of staff changes. It was difficult to see whether there had been sufficient staff on duty as staff could not remember whether when a staff member had been marked absent whether agency or other staff filled that position.

Some people either through choice or because they were ill choose to remain in bed. We observed staff attending to people's needs. They ensured they answered people's call bells and politely asked what they required before fulfilling the person's wishes. However, some people told us call bells were not always answered in a timely manner. One person told us they had not had to use their call bell, but we saw it was out of their reach so moved it closer to them. We timed the call bells being answered through out the day. The busiest times were mid-morning and lunchtime. Staff took a long time to answer, but they apologised if people had to wait. People told us that during the mid-morning period they mainly had to wait to be transferred from their bed to a chair and move out of their bedrooms' to a sitting room. At lunchtime we observed people having to wait to use the toilet before and after lunch was served. This made people anxious and two people told us they were frustrated, as going to the toilet quickly was important to them.

This is a breach of Regulation 18 of the Health and Social Care act 2008 (Regulated Activities) Regulation 2014.

People and relatives told us they felt safe living at the home. One person said, "It's as safe as anywhere. They don't bully us either." Another person told us, "I've always felt safe here. I've seen nothing bad." Although one relative told us, "I don't think [named relative] is safe. I came at the weekend and she hadn't got her walking stick and hadn't had the previous day apparently. I found it in the lounge where [named relative] usually is, why hadn't anyone thought to look?" We passed this message on to staff to investigate.

We received mixed views from people regarding safe handling and equipment. Some people told us staff were gentle with them when helping them to move, whilst others had a different view. One person said, "I've got all the equipment I need to walk. The staff are always kind helping." Another person told us, "They're not always gentle with me." However, they went on to tell us how some of the equipment they had been using was no longer safe so staff had arranged some new equipment, which they felt was better. People also told us they felt their belongings were safe. One person said, "I've no problems at all." Another person told us, "I lost a pen once, but I think my daughter probably fancied it. All else has been fine."

People told us that staff made checks on them day and night to ensure they were safe and if they wanted anything. Comments included. "They check on me day and night. I'm a light sleeper so I see them." Another person said, "They peep in every few hours."

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the registered manager would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a monthly basis. The records ensured any investigation action was recorded and lessons learnt from any incidents. This ensured any changes to practice by staff or changes which had to be made to people's care plans was passed on to them. This was through shift handovers and meetings. We saw this in the staff meeting minutes for September 2016, when issues about possible poor practice had been discussed with staff.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks. For example, where people had a history of falls and difficulties mobilising around the home. Falls assessments had been completed. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct equipment was in place for each person. Permission for the use of bedrails had been sought and were now in place. This was recorded in each person's care plan. We observed staff assisting people to use a variety of walking aids throughout the day. Staff gave reassurance and advice to each person on how to walk safely around the building. This was to ensure each person was capable of being as independent as possible.

Staff used a scoring tool, called a Waterlow score, to give an estimated risk for the development of pressure ulcers. The total score can depend on what treatment could be given to each person. We found that staff had not completed these correctly in two cases. For example, one person had a score of 3 because staff had scored the person to be urinary and faecally incontinent, yet the person had a catheter in place. This would not make them urinary incontinent. The weight loss of another person had not been acknowledged by staff, so the scoring was incorrect. This could put people at risk of not receiving the care required to ensure they

did not develop pressure ulcers and what equipment they may need to prevent those ulcers forming. The instances were discussed with staff, who were going to review the Waterlow scores for those people we identified.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because of poor mobility. A plan identified to staff what they should do if utilities and other equipment failed. Staff were aware of how to access this document.

We were invited into six people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. They told us they were happy how their rooms were kept clean. However, staff had not taken into consideration when writing the care plans of environmental risks for some people, especially those with mobility problems or loss of vision. This did not ensure rooms were free of trip hazards from trailing wires and ensuring furniture was in a good state of repair.

The entrance to the home was through a door, which was open at all times during the day. There was a receptionist on duty during the day, who we saw reminding visitors to sign in the visitors' book. People told us they could exit the building if they wished by using the latch on the door and told us they reminded staff they were out of the building. All areas of the garden were safe to walk in and there was no direct entry to the gardens from the main road. It was possible for people to have locks on their doors, but at the time of the visit no one wished to use this option.

People had name plates on their bedroom doors, which enabled them to identify which room was theirs. Some people choose to have pictures on their doors which meant they could recognise them quickly. There were also signs on the doors indicating what each room was used for, for example, a sitting room or toilet. The signs were in words and pictures. However, there were no directional signs in corridors to direct people around the home, other than fire exits. This could mean that people who had a poor memory could walk for a long time until they found where they wanted to be.

We looked at two personnel files of staff. Checks had been made to ensure they were safe to work with people at this location. The files contained details of their initial interview and the job offered to them. There were no current staff vacancies.

People told us they received their medicines each day. Some people told us at times their medicines were left with them so they could take them later in the day. However, at the time of our visit there was only one person who could take their own medicines without being supervised. This was discussed with staff to highlight they needed to ensure every other person takes their prescribed medicines. Other people told us that a nurse would supervise them taking their medicines. One person said, "They bring them in and leave them with me. They plonk the pot and drink on the table and say "Enjoy". They don't come back and check on it." Another person said, "I have nine tablets in a morning. If I'm in the bathroom, they'll leave them for me with a drink." Another person told us, "They bring me tablets and stay with me" and another person said, "She waits with me and gives me a drink for the pills."

Medicines were stored in line with current guidance. The temperature of the refrigerator and room were checked daily and staff were able to describe what they would do if the temperatures were not within the desired ranges. A record book was in place for those medicines requiring special storage and administration. The entries followed current guidance. Records about people's medicines were accurately completed. Each medicines administration record (MAR) had a photograph of the person, which bore a resemblance to that person plus other information such as allergies. For example one person was allergic to

ciprofloxacin and was not prescribed it. Another person had a protocol in place for the use of paracetamol. This included its indications and dosage. Where a person was receiving transdermal medication (patches) there was a patch rotation chart, which is good practice to show where the last patch had been placed.

A person had a sign on their room stating they were using oxygen. This was longer the case and after discussing with staff they removed the sign. This could cause confusion in the event of a fire as it would be part of an evacuation plan, which made that plan invalid. Staff had removed the labels on thick and easy products being used for two people. No rational for removing those labels could be described by staff. People should only receive medicines and products prescribed for them.

Medicines audits we saw were completed by staff at the home and the pharmacy supplier. We saw the last audit from September 2016, which the provider had completed, which highlighted actions which had now been completed. The policy for administration of medicines had not been reviewed since July 2012 and included only a few topics. We were informed by the deputy manager that this was being revised, but we did not see the latest version.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and how important it was to take it. They stayed with each person until they had taken their medicines. Staff who administered medicines had received training. Reference material was available in the storage area and staff told us they also used the internet for more detailed information about particular medicines and how it affected people's conditions.

Requires Improvement

Is the service effective?

Our findings

We received mixed feedback from people about the skills and capabilities of staff to care for them. People talked about the staff ability to uphold basic skills such as being always polite and knowing how to approach those who had problems with hearing. One person said, "I don't' think they're trained as well as they could be, in politeness and social skills really." Another person told us, "It used to be much more professional. Now they are under a lot of pressure and maybe not so competent. I hear them ask one another about how to do something." A relative told us, "They seem fine and capable to do their job." Another relative told us, "The basic care needs are not met. They don't have the skills for dealing with a nearly deaf person and for dealing with the elderly with issues." There was no evidence staff had completed courses in communication skills, customer awareness or sensory needs of people, which would give them a better understanding of how to communicate with a variety of people.

None of the staff we spoke with had been newly recruited. However, they told us that the induction programme at the time of their initial days at the home had suited their needs. They told us what the programme had consisted of, which followed the provider's policy for induction of new staff. Details of the induction process were in the staff training files. The deputy could not confirm whether the Care Certificate was used to support new staff on induction.This would give everyone a new base line of information and training and ensure all staff had received a common induction process.

Staff said they had completed training in topics such as manual handling, fire and health and safety. Some staff had complete training in particular subjects such as dementia awareness, pressure ulcer prevention, stroke awareness and nutrition.They told us training was always on offer and they had a test to see if they had passed the courses they had undertaken. However, following training there was no evidence to support that staff skills and competency had been reviewed and they had put their course knowledge into practice. Training was recorded on a computer data base. This recorded what topics staff had covered and gave a percentage score for each topic. For example, infection control was 88% of staff completed and first aid awareness 52%. Any shortfalls of staff not attending courses were addressed at staff supervisions. There were several topics of training advertised for staff to attend.

Staff told us the provider was encouraging them to expand their knowledge by setting up courses on specific topics. This included national awards in care and being encouraged to attend local support groups in topics such as infection control and end of life care. The professionally trained nurses were being supported to maintain their registration with the Nursing and Midwifery Council (NMC). Staff told us they could approach the registered manager and deputy manager at any time to complete their revalidation with the NMC. The registered manager kept a list of dates for each staff member concerning their revalidation. Staff told us they were supporting each other to ensure the revalidation forms had been completed correctly.

Staff told us a system was in place for formal supervision sessions. They told us that they could approach the registered manager and deputy manager at any time for advice and would receive help. The records showed when supervision sessions had taken place, which was in line with the provider's policy. There was a supervision planner on display showing when the next formal sessions were due. All staff had received at

least two formal supervisions since January 2016. This was a combination of individual sessions and group sessions with staff. The professionally trained nurses were also encouraged to attend clinical supervision meetings. We saw the minutes of the one for August 2016. This covered topics a number of different topics and staff had opportunity to ask questions. Their replies were recorded.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirement in the DoLS. Two applications had been submitted to the local authority and the provider was waiting for authorisation. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS. 90% had completed their training and there were further sessions planned.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times best interest meetings had been held and assessments completed to test their mental capacity and ability. However, on one record this was not decision specific, for example it stated, "To determine [named service user] level of capacity." We pointed this out to staff, who went to correct this record.

People told us that staff did not always ask their consent before giving care. One person said, "They don't ask me. They just tell me what they're going to do." Another person said, "They don't ask permission. They just get on with it. They're always nice and chat." A relative told us, "I've not noticed them ask [named relative]."

People told us they had some freedom of movement and could make decisions. One person said, "I can go where I like around the building. I can go out to the shop too if I wanted a walk." Another person told us, "I have to be asked to be moved but can ask where I want to go and sit."

Feedback we received from people on the food provision was varied regarding the content and variety. They told us that if they wanted a different choice to the menu staff would obtain it. One person said, On the whole, it's good. They ask us on the day what we want. We would have to ask early if we wanted something different. Family can join us if they ask." Another person said, "I don't' have the gravy type dinners. It's bland and tasteless so I use my own salt and pepper. They would get me a piece of fruit if I asked for it."

Staff knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes,

foods to avoid and the type of diet required. Staff told us they were trialling an outside firm to provide a soft diet for one person. This had been discussed with that person and the discussion recorded in the care plan. Staff were happy the meals being provided by this supplier had listed all the calorific value of each meal. This ensured people received what they liked and what they needed to remain healthy.

Menus were on display within the kitchen area, but not in dining rooms. This meant people could not use the menus as a reminder to the day's choices. Unless people asked this was not discussed with people until each meal was served. A large number of people ate in their bedrooms and the dining areas only had eight people in, across several dining areas. Meals were taken to rooms by staff who ensured covers were placed over the plates. We observed staff assisting people to eat and drink in an unhurried way and maintaining eye contact. We saw hot and cold drinks provided throughout the day and jugs of water or juice put in people's rooms. Some families had provided mini fridges in people's rooms which contained soft drinks. People told us they had sufficient to drink.

People told us staff obtained the advice of other health and social care professionals when required, but there were mixed views over the provision of dental services and the timely referral for some health professionals. One person told us, "[Named supplier] are bringing me in new glasses and I get my own chiropodist coming in to me. I use the hair salon here." Another person said, "I've just got new glasses. The chiropodist comes regularly and the hair dresser is very nice. My daughter does my finger nails, but I hear carers doing other people." A relative told us, "A dentist isn't available to come in apparently. [Named relative] gets the chiropodist coming in and carers do [named relative] nails." Although the provider told us that a community dentist was available, we did not see in care plans that these services had been offered to individuals. People told us they wanted the services of other health care professionals, but that staff tried to make appointments, but this took a long time.

In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people required the advice of a respiratory nurse or tissue viability nurse. Staff had recorded when people had seen the optician. Several people had hospital appointments which they had attended. Staff had recorded outcomes of those visits.

Requires Improvement

Is the service caring?

Our findings

People told us they liked the staff who were usually kind and helpful. One person said, "They're all very kind." Another person said, "I find them polite and caring." A relative told us, " On the whole, the staff are ok." People told us they felt comfortable and listened to be staff. One person said, "I feel at ease with the staff so far." Another person told us, "I can get on with them and we have a laugh together. I have no qualms about being with them." However one person told us, Some are very good, gentle and kind. Some are a bit sharp and make me want to cry. They nag and rush me." We saw there had been several safeguarding referrals made about the type of comments this person had made, which had been investigated, with no conclusive outcomes.

Most people told us staff treated them with dignity and respect at all times. Although this was not the experience of some people. People told us staff knocked on doors, which we witnessed. One person said, "They knock even when my door is open." Another person told us, "They knock and come straight in. But they do close the curtains for privacy for me." The person told us they had asked them to knock, but that the staff rarely remembered before opening the door. People told us staff had even given them their post when they were in the middle of a bath, which they told us they did not like. One person said, "I like to open my post in private and give myself time. This does not always happen."

During the lunchtime period we observed there was little discussion with people about their meal. We observed plastic apron bibs were placed on some people, but we did not hear staff asking their permission to do so. We were told by staff they knew which people needed plastic apron bibs as they liked to eat their food unaided and the bibs protected their clothes. However, we observed staff also placing bibs on people they were assisting, which did not require bibs.

The people we spoke with told us they were supported to make choices and their preferences were listened to. One person said, "I get up at 7am and sit around until they help wash me about 8am. If they don't turn up then I'll manage by myself." The person expressed a great deal of frustration about those incidents. Another person told us, "I'm lucky I can get myself up. I hear carers ask other people if they'd like to wear what they have chosen out the wardrobe." A relative told us, "[Named relative] gets anxious, so making decisions is difficult for [named relative] but they will ask, because they are supposed to. But it is so much better if they plan and suggest and cajole, without asking [named relative] to make decisions every time. I know [named relative] can be difficult, but it works for me."

People were given choices throughout the day if they wanted to remain in their rooms or bed or where they would like to sit. Very few people joined in events in communal areas. Others declined, but staff respected their choices on what they wanted to do. There were also quiet areas in corridors where people could sit. We observed people in those areas, some with their relatives, and some with staff. Independence was encouraged when people had the ability to assist in their care. One person said, "They want me to be independent and what I can reach, I'll wash." A relative told us, "[Named relative] will go where [named relative] wants, when [named relative] wants and chooses which activities too."

All the staff approached people in a kindly manner. They showed a great deal of friendliness and consideration to people. They were patient and sensitive to people's needs. For example, when someone wanted help to move about the building. This was offered and the staff member was seen talking animatedly to the person whilst they walked together. A staff member was seen in a corridor talking quietly to a person who was upset. They offered to go to the person's room with them, which was declined. Later the person was seen less distressed and talking to other people who were laughing about an event which had happened.

Throughout our visit we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made.

People and relatives told us they could have visitors whenever they wished and this was confirmed by relatives. One relative said, "We've no limits to times. We use a lounge often to sit together." Another relative told us, "The staff are lovely with me. I can come in any time and they always make me a drink." We saw signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families visited on a regular basis. This ensured people could still have contact with their own families and they in turn had information about their family member. People told us staff would telephone their family members when they wanted to speak with them.

All members of staff were involved in conversations with people and relatives. Each staff member always acknowledged people when walking around the building. Staff greeted people with their first names if this was their wish.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The registered manager understood their responsibilities and knew of other resources they could use for advice. This home is part of a small company so the registered manager had the opportunity of meeting with other home's managers, area staff and head office staff on a regular basis. This was welcomed by the registered manager and deputy manager as extra resources for advice and support.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local lay advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display. There were no local advocates being used by people at the moment.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with told us their care was not always personalised, but that their basic needs were generally met. They told us staff did not spend quality time with them. One person said, "It doesn't feel personalised for me. They've only got time for the basics." Another person said, They realise how fragile I am now and take extra care of me." A relative told us, "[Named relative] basic care needs are not met, let alone anything more." Another person said, "They've all too busy. They wouldn't bother sitting for a while."

Only one relative told us they were involved in the care planning process of their family member. No other relatives or people had any direct involvement with their care planning process. People told us of other relatives who were involved in speaking to staff about their care needs. This was not always documented in people's care plans. This means staff were not attempting to speak with people about their specific needs and if the care and treatment satisfied their needs.

People told us that availability of a shower or bath to suit their preferences was not always respected. We saw that care was delivered in a way that was task-focused rather than person-centred, for example staff worked off a list for weekly baths and showers for people, rather than these being available to people as and when they chose. One person said, "We have to go on the list for a bath. It should be once a week." Another person told us, "I ask for a weekly shower now after problems with long times without one. I get a daily wash-down too." We saw a list which gave details of when people would have a bath or a shower. Staff told us they tried to keep to the list so people had one or the other once a week. Staff told us people could have them whenever they wished, but only weekly baths and showers were recorded in the care plans and it was not recorded if staff had asked if people wanted baths and showers at more frequently.

In four care plans we looked at people had Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR). In each case the DNACPR forms had been correctly completed. Staff had documented discussions they had with people and their relatives about their end of life decisions. This is good practice to discuss this before a person becomes ill. People had discussed with staff topics such as preferred form of disposal such as a cremation and preferred place of where they would like to end their days such as the care home or hospice.

The care plans we looked at included assessments on people's oral hygiene, elimination, skin integrity, mobility, nutrition and personal hygiene. They were informative and identified each person. Other specific information was included, depending upon people's needs. For example instructions for the use of an inhaler, negotiations with the local Blind Society and responses from tissue viability specialists. The care plans had been updated monthly. The entries varied from a few words such as 'no change' to 'new medicines helping with anxiety.' They did not refer to the charts in place for people and if more or less observations were required, even when changes had taken place.

Some people had specific charts in place so staff could track what care and treatment had been delivered. We had to bring to the deputy manager's notice that the blood pressure readings for one person varied dramatically over a short period of time. Staff explained that two blood pressure reading machines were used. Both were tested during our visit and each gave different readings. The deputy manager took remedial

measures to ensure a correctly working machine was put in use. This could mean that vital signs of a person could be missed and they could become ill.

Staff recorded weights of people who had a poor nutritional intake and some people's food and fluid intake was also recorded. We looked at the mattresses of five people who also had weights taken. The level the pressure mattresses are set is determined by the weight of each person. Four mattresses were set at the incorrect level and one mattress was deflated. This could mean people were at risk of pressure ulcers and being uncomfortable if the mattress was not set at the correct level. We brought this to the notice of the deputy manager, who instructed staff to attend to the mattresses.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. There was also a handover book in use for reminding staff of tasks yet to complete, such as calling a GP or ordering medicines.

People told us about their involvement in activities. Some people told us they liked their own company, others enjoyed certain activities, but no one described days out. One person said, "I have a few friends here now that I can go and chat with if I want." Another person said, "Bingo and mars bars on a Thursday are my favourite. We do colouring and there is a monthly church service with hymns and prayers." People who preferred to stay in their rooms described that few staff spent quality time with them. One person said, "No-one comes to do anything in the room."

We were informed that an activities co-ordinator was employed and they were present on the day. There was also a part-time staff member whose speciality was cookery plus a volunteer. There was a separate activities room, which was at the end of a corridor. This meant it took time for people to be collected in wheelchairs to access this area and people also had a long walk before reaching it. A call bell was located in the room if assistance was required. We observed a mid-morning activity of a shopping trolley quiz with simple mental arithmetic, 18 people took part. The event ended by people having a drink and a chat. The activities co-ordinator and volunteer worked on their own. There was no participation from other staff.

A monthly list of activities was produced and taken to each person's room and was also on display in the reception area. This listed activities such as dominoes, crafts, film afternoons and a monthly church service. We saw in one person's care plan that their particular religious preference had been documented. This contained special instructions to staff on what religious occasions through the year they would like to be involved in. Staff told us there was very little time for one to one activities for people who wished to stay in their rooms, but that they chatted to everyone each day. Staff said no outings had been arranged recently due to a lack of wheelchair minibus hire or appropriate taxis in the area.

Staff had little time to spend quality time with people to discover the people's interests, hobbies and social needs. Due to a lot of people spending lots of time in their rooms they could become isolated if staff did not spend time with them. The involvement of outside agencies coming into the home to help stimulate people's interests was limited as staff had little resources to discover what was available locally.

The activities co-ordinator kept a diary of all the events people had taken part in. They had also just commenced recording people's life histories, but this was proving a long task as sometimes people became upset. Staff had also included within the care plans people's preferences for joining in social activities and what interests they had prior to coming to the home. The provider had given a sum of money each month for the sole use of the activities co-ordinator, which we were informed was a 'generous amount'. This was used to provide equipment and other items such as craft resources.

People are actively encouraged to give their views and raise compliments, concerns or complaints. People's feedback was valued and concerns discussed in an open and transparent way. People told us they were happy to make a complaint if necessary and felt their views would be respected. Each person knew how to make a complaint. People told us when they had raised a complaint and if they had received a satisfactory outcome. One person said, "I've had nothing real or terrible to raise. I'd talk to both the managers ok."

We saw the complaints procedure on display, but this had not been reviewed since October 2013. This did not give people the opportunity to discuss their concerns with an outside agency, if they felt the internal complaints process had failed them. The complaints procured contained information about CQC, but not about the local ombudsman who could help people with their concerns. The deputy manager stated this would be corrected immediately. The complaints log detailed the formal complaints the manager had dealt with since our last visit. It recorded the details of the investigations and the outcomes for the complainant. Lessons learnt from the cases had been passed to staff at their meetings in 2015 and 2016.There was one complaint outstanding, which a relative shared with us and we saw on the complaints log. They are hoping for a quick resolution.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. People told us they could express their views to the registered manager and deputy manager and felt their opinions were valued. Although some people told us it was a long time before answers were given to queries raised. People told us the manager was visible and approachable. One person said, "I see one every morning and they acknowledge you. I can talk to them." Another person told us, "I see her [named staff member] some days and can talk to her easily enough."

There was sufficient evidence to show the registered manager had completed some audits to test the quality of the service. These included infection control, a kitchen audit and a maintenance monthly review Where actions were required these had been clearly identified and signed when completed. Any changes of practice required by staff were highlighted in staff meetings, in the communication book and shift handovers so staff were aware if lessons had to be learnt. However, the effectiveness of audits after information had been passed to staff was not robust enough. For example, there were maintenance issues of equipment, which was impacting on the daily care people received. The care plan audits did not follow up supporting evidence such as Waterlow scores and blood pressure readings to ensure staff were following the care plans so people were not at risk of harm. Staff did not always follow the advice in the care plans through to daily charts and observations and this was not monitored by senior staff. Where people had expressed concerns their care was not being delivered, due to having to wait for staff to help them, this was not taken into consideration when suitable staffing levels were being calculated.

The management company currently overseeing the home had produced an action plan for the registered manager to follow. This covered areas such as care plan reviews, staffing levels and looking at the recruitment drive. When completed the actions were signed off by an area manager. The management company kept CQC in touch with the progress of the action plan on a regular basis. The action plan dates had been revised for some items due to senior staff sickness levels, so there were still a number of actions still to be completed.

Questionnaires were sent to people on a yearly basis and the last one was in July 2016. The results were displayed in the reception area. The results showed 44% of people had replied with mainly positive comments. Where action had been taken for issues raised the details were displayed. For example, a change in menus, taking into consideration people's requests. People told us they had completed questionnaires. One person said, "I did a little printed paper recently. I think suggestions they're open to." A relative told us, "I don't' fill anything in as they code them so they know who said what." However, they told us they would not be worried about raising a concern. People and relatives told us of things they would like to see improved or were particularly good. This included requesting music playing in the background, answering call bells more quickly, but also being happy as it was that day.

People and relatives told us they had the opportunity to attend group meetings with the registered manager and other staff. We saw the minutes of the meetings for September 2016 where a number of topics were discussed; such as housekeeping, maintenance, care concerns and the running of the kitchen. People told us they had been given the opportunity at the end of the meeting to ask questions and the responses

recorded. One person said, "They've just had one and relatives could come to." Another person said, "They do ask me what I think as I can't make it along to meetings from bed." Relatives were less complimentary about the meetings, but told us they could go to them if they choose to. One relative told us, "I don't go and don't hear any feedback. My [named relative] comes in." Another relative said, "It's no good speaking up at these meetings as nothing gets done." However, people and relatives told us they would still attend meetings if they could and would continue to speak up if they needed to.

Staff told us they worked well as a team and felt supported by the registered manager, deputy manager and senior staff. One staff member said, "I'm still happy to come to work." Another staff member told us, "I just love working here and working with the people." Staff told us staff meetings were held. They said the meetings were used to keep them informed of the plans for the home and new ways of working. We saw the minutes of the staff meeting for September 2016. The meeting had a variety of topics which staff had discussed, such as care issues and staffing. This ensured staff were kept up to date with events. Staff told us they felt included in the running of the home. The minutes of the meeting showed staff were given time to express their views, with explanations given, if possible, or suggests for moving forward.

The deputy manager was seen walking around the home. They knew the names of all the people, relatives and visitors. They gave support to staff when asked and checked on people's needs. The deputy manager was visible throughout the day showing compassion and respect to people and assisting staff when they needed help.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not taken into consideration the complex needs of people. Therefore there were insufficient staff to meet people's needs.