Mr Paul Bliss

Leonard Elms Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Leonard Elms Care Home provides accommodation for up to 73 people who require personal care and nursing. The home comprises of two units, the Elms and the Cherries; the Elms unit is for general nursing care. The Cherries unit specialises in dementia care and has recently gained a level three accreditation in the Butterfly Project by Dementia Care Matters. This is a specialist approach designed to be person centred and enter the world of the person with dementia. On the day of inspection there were 55 people living at the home. The accommodation is arranged in two buildings – one for each unit.

This inspection was unannounced and took place on 28 and 29 October 2015.

There is a registered manager in post for the home. 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. However, we were told that the registered manager has not been actively at the home for three months; the

Summary of findings

provider has an acting manager in post, who is a registered manager for another home owned by the provider. The acting manager is supported by the registered manager and operations manager.

People told us they felt safe but there were risks to their safety including pressure care and medication management. Key staff had not received training in pressure care and the management systems did not always identify pressure wounds. Medication procedures were not following best practice and this was putting people at risk. The upkeep of the building was potentially putting people at risk and there were concerns about measures in place to prevent fires. Issues were found about the storage of food in fridges and freezers.

There were concerns about the supervision and training staff received. The staff were aware of their responsibility to protect people from avoidable harm or abuse and some staff had received training in safeguarding. Staff knew what action to take if they were concerned about the safety or welfare of an individual. They told us they would be confident reporting any concerns to a senior person in the home and they knew who to contact externally. The recruitment process followed good practice.

The provider and senior management had some understanding about people who lacked capacity to make decisions for themselves. However, many of the staff had not received appropriate training. Care plans had not made it clear the consultation process when people lacked capacity or that people had decision specific assessments. When there were decisions to prevent people leaving the home for their safety the correct processes had not always been followed. As a result, there were breaches of people's human rights.

The registered manager and provider had not followed their legal obligations to notify CQC of their absence and they had failed to notify CQC of other incidents. The acting manager told us that they had not completed any up to date quality assurance procedures; the systems were not identifying all shortfalls in the home.

There were concerns around care plans for people because they were not always complete; in some cases people had no care plan. These plans did not have a person centred approach to them; this means that people were not central to their care and decisions being made. The use of a computer based system meant that generic phrases were created for people rather than specific ones to reflect their needs and wishes. Care plans were not always responsive to changes in people. Staff had some knowledge about the care plans, but explained they found it difficult to access them because there were limited computers.

Staff supported people to see a range of health and social care professionals to help with their care. Staff supported and respected the choices made by people especially in the Cherries Unit.

People had a choice of meals, snacks and drinks, which they told us they enjoyed. The chef provided alternative options if people did not want what was on the menu to ensure their preferences were met.

People and their relatives thought the staff were kind and caring; we observed mainly positive interactions. The privacy and dignity of people was respected most of the time and people were encouraged to make choices throughout their day.

People knew how to complain and there were good systems in place to manage the complaints. The registered manager and acting manager demonstrated a good understanding of how to respond to complaints.

The acting manager had some visions for the home and had some systems in place to communicate this.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and breaches in the Care Quality Commission (Registration) Regulations 2009. We are currently considering the action we will be taking.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People's medicines were not administered correctly or followed best practice and there were concerns around people's pressure care.

Parts of the home were not maintained to a standard to keep people safe and there were concerns about the storage of food. There were risks in the event of a fire as some of the equipment was missing and safety measures were broken.

There was a high use of agency staff. Staff generally understood how to keep people safe and who to tell if they had concerns about people's safety.

Risks of abuse to people were minimised because there was an effective recruitment procedure for new staff

Is the service effective?

Requires improvement

The service was not always effective.

The management demonstrated some understanding about making best interest decisions on behalf of someone who did not have capacity, but the staff had little knowledge. The home did not follow the code of conduct for making important decisions.

Even though people were being kept safe with a locked door; people were at risk of their human rights being breached because the correct procedures were not being followed.

Some staff had training to meet the needs of people they supported; but large numbers had not received training in areas such as capacity and consent.

People were supported appropriately to eat and drink and there was access to other health and social care professionals.

Is the service caring?

Requires improvement

This service was not always caring.

People told us that they were well looked after and we saw that the most of the time the staff were caring.

People were involved in making some choices about their care.

Most people's privacy and dignity was respected.

Is the service responsive?

Requires improvement

The service was not always responsive

There were limited activities available to people in the home and at times this was due to resources

Summary of findings

Some people had care plans that were not always completed or personal to their needs and wishes. Some people had no written care plan.

People knew how to make complaints and there was a complaints system in place.

Is the service well-led?

Inadequate 

The service was not well-led.

The provider and registered manager had not completed their legal obligation of notifying CQC of incidents and the absence of the registered manager.

The service had out of date quality assurance systems and those they had completed had not identified all shortfalls in the home.

The acting manager had a vision for the home and some staff were effectively supported.

The acting manager kept their knowledge and skills up to date so they could provide effective support for the people.

Leonard Elms Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 and 29 October 2015 and was unannounced. It was carried out by three adult social care inspectors, two specialist advisor nurses and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. One nurse specialised in dementia care and the other nurse specialised in pressure care.

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. The information that we would have got from this form was collected during the inspection. We looked also looked at other information we held about the home before the inspection visit.

We spoke with seven people that lived at the home. We spoke with the registered manager, acting manager, operations manager and 26 members of staff including kitchen staff, nurses, activities coordinators and care staff. We spoke with three visitors or relatives and with three health and social care professionals and four other professionals from environmental health and the fire service.

We looked at 12 people's care records and observed care and support in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at nine staff recruitment files and seven staff training files, previous inspection reports, staff rotas, the complaints file, various records including kitchen checks and a selection of the provider's policies.

Inadequate

Is the service safe?

Our findings

Even though some people said the home was safe there were areas that placed people at risk. For example, management and storage of medicines, pressure care, the environment and fire risks. Medicines were not managed safely or effectively and were inconsistently stored across the units. Following the inspection the provider told us each system was chosen to benefit the residents. The medicines fridge on Cherries contained an expired flu vaccine and the fridge temperature was not being monitored despite a notice informing staff to record the temperature daily. This meant there were no assurances that medication was being stored at correct temperatures to prevent damage. On Elms unit, bottles of liquid medicines stored in a medicine trolley had not been dated and signed when opened. This meant there was a risk that people could be administered out of date liquids.

One of the medicine administering charts was missing a photograph of the person on the front. The administering charts on Elms and upstairs on Cherries contained information for the nurse administering medicines on how people preferred to take them; for example "X prefers to have their tablets on a spoon" and "Rarely refuses medication". This kind of information was not available downstairs on Cherries; most people on the Cherries unit had communication difficulties. The missing photograph and lack of information meant there was a risk of administration errors, particularly because the service was relying on agency staff that might not be familiar with the people using the service.

Some people's medicines had not been given or the dose had been wrong due to lack of stock. One person had received only half a dose of their prescribed pain medicine because the correct dose had run out. There was a risk this person would have been in pain. Another person had no prescription medicine because the prescription had not been arranged with the local doctor. By missing medicine or not having the correct dose people were at risk of health needs not being met.

One person's medicine charts informed staff to crush their medicines if needed; there was no documentary evidence this had been discussed with a pharmacist or doctor. By not seeking advice from the correct professional before crushing, staff were not aware if this affected how the medicine worked and the way the active ingredients are released. This meant there was a risk that prescribed medicines might not be as effective as they should be.

Some medicine errors had been reported as incidents in the home but not all had. When incidents had been reported, there had been no subsequent investigations and no changes in processes as result of learning from incidents. We looked at two recently reported incidents. For one incident there had been contact with a doctor and close observations should have occurred. The acting manager said she was on annual leave and had no memory of the incident. Members of staff said close observations should have taken place as instructed by the doctor; only two sets of observations were recorded although staff members said they did more. There was another incident relating to poor medicine practices by a member of staff but there were no records of these discussions or actions that had been taken to prevent reoccurrence. There were no records that either incident had been discussed with the team to prevent any recurrence and only one incident had been signed as "closed". The remaining open incident had taken place in June 2015. Therefore, there were not systems and processes in place to investigate allegations around medicine incidents in the home.

People were not always safe due to concerns around the management of pressure care; this meant people were at risk of sores on their skin caused by pressure being placed at specific points. There was no daily reported skin inspection for people considered at risk. Some staff said, "We automatically check when we assist with personal care". There were no daily checks recorded so new sores may not be identified in a timely manner.

Other risks to people were not being managed well. For example, risk assessments had not been completed for three people on admission with pressure ulcers. This meant people were at increased risk of health problems related to pressure care. One person had bed rails in use, we asked a member of staff for the risk assessment and consent form for the use of these but there were none. A member of staff confirmed that one person was being given additional close support at certain times of the day. Another person had complex behavioural needs that placed staff at risk. Whilst staff who knew the person well were able to keep safe there was no recorded guidance

Is the service safe?

provided to staff about triggers, risks and the management of this. The acting manager said they managed this risk through support and medication reviews that had been organised with health and social care professionals. They also said staff were informed of risks through handovers. However a member of staff was not aware of the current risks despite this process.

There were high levels of falls being recorded by the home; however, records about the incidents did not include actions taken and lessons learnt. During a staff meeting in May 2015 staff were told that the falls which resulted in no injury would be recorded by "Not having to fill out the incident form. There will be a form in the front of the incident folder". This meant that detailed investigations would not be completed about falls and the senior staff may not be made aware at the time of the incident. The monthly audits by the acting manager, senior nurse or operations manager recorded the quantity of falls and sometimes which person. However, there was no further investigation about each fall. We spoke to the acting manager who said when there were serious incidents they would meet with staff and go through an explanation of the incident. They would look at triggers and the environment as well as how the incident was managed. Therefore, there were limited systems in place to identify patterns of falls and investigate them; there were no records of actions that had been taken. People were at risk of preventative action not being taken fallowing a fall.

Some people had special air mattresses to reduce the risk of pressure sores. There were a range of mattresses in the home; they had different settings such as 'low to moderate' or 'one to four'. However, there were no instructions in place for which setting each mattress should be on. Staff were aware mattresses should be inflated to people's weights but some of the mattresses could not be set like that. A member of staff said "We go on the feel of the mattress when we push on it"; another member of staff confirmed this to be the case. Additionally, the mattresses were quite outdated and posed a risk for people because staff opinions were relied upon rather than a set of instructions for each mattress. This meant people's health and welfare were not protected from the risk of pressure wounds.

We spoke to the acting manager about pressure care and they said "We need to report deep pressure ulcers to safeguarding, but we wouldn't report them if the patient was palliative". Palliative care means treatment that improves the quality of life for a person facing a life-threatening illness. When we asked for further information the acting manager said there were none currently in the home. According to staff and records there was one person that was palliative care and had a pressure ulcer; the acting manager was unaware of this person. They advised us that they will look into this. Following our inspection this was reported to safeguarding. Staff and the manager's assessments were not identifying people that required pressure care; people were at risk of developing pressure wounds and having related health problems.

This is a breach in Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not safe and protected from risks to their health and welfare because parts of the premises and equipment were not clean, secure or properly maintained. For example, fridges and freezers currently in use were located in a spare bedroom. One chest freezer, with food in, contained mould on the inside of the door. Another freezer had a broken rusted top with unsealed bags of food inside. Meat was being stored above dairy products in a fridge. Sandwiches had been made but were unlabelled; this meant it was not clear when the food had been prepared and how long they had been in the fridge. There was a heated food trolley being used that had stains all down the side and old food along the doors at the front; inside were uncovered fish cakes. The main fridges had significant accumulations of dirt down the sides. This meant people were at greater risk of harm from the food they were eating. We spoke to the acting manager and the operations manager who explained that they would get the head chef because this was their responsibility. The head chef told us he had contacted environmental health because of concerns raised during the inspection. The head chef said they were speechless about how the meat had been stored because it should not have been stored like that. The head chef and chef showed us cleaning schedules and training certificates; there were some gaps on the cleaning schedule from the last week. We asked how the provider and management checked the processes and quality assurance systems that were in place for the kitchen; the head chef explained the home's quality assurance systems did not cover the kitchen.

There were chemicals being stored in an unlocked boiler room. The boiler room was located down a corridor that

any person could access. The operations manager said they did not know if the chemicals should be locked away; they continued by saying they thought the door was usually locked. It was later found unlocked despite having raised the concern with them. By the second day of the inspection there was a new key code lock on the door rather than a key lock.

The Elms unit was not properly maintained; there was a hole in the wall and skirting board near the kitchen exposing metal. There was a hole in the wall outside of the boiler room and there were gaps between the flooring and skirting boards in this area. The skirting boards and walls were generally chipped and marked in this area. The downstairs visitor's toilet flooring was not sealed because there were gaps between the floor and skirting boards, the tiles around the sink were stained in the grouting, the bin had no lid and the door frame and skirting board paint was chipped. There was a bathroom upstairs that had a toilet not working correctly; there was no sign to say it was out of use. All these provided hazards to the people living at the home because they were at risk of hurting themselves on damaged walls or using a toilet that did not work. We spoke to the registered manager, acting manager and operations manager who all confirmed the bathroom with the broken toilet was no longer in use. They shared their plans for renovations of certain areas in the Elms unit that should resolve these issues. Further risks in the environment were found in the Cherries unit; in the central courtyard there was a large stone covering a small area of wooden flooring that was broken. One paddling plastic pool was severely broken causing a risk of people cutting themselves. Also in this area was a semi-deflated three foot beach ball. Again this was a risk factor of possible tripping or slipping especially for people unsteady on their feet.

In the Cherries unit there were fire extinguishers missing from their designated point. We spoke to the acting manager who located two fire extinguishers; one of them was wrong type because it was different to the signs on the wall. This meant that people would not be able to easily access the correct fire extinguishers in a fire. We contacted the fire department as a result of our findings.

This is a breach in Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People said they were not supported by sufficient numbers of staff to meet their needs and keep them safe. One person said "The staff never forget to come and support me. If they are busy I have to wait". They continued explaining that the weekends are the worst staffing levels. A relative said the home is "Well understaffed" and another relative said "Not enough people around. It can be quite upsetting seeing people calling but no one comes." Staff comments about staffing levels were mixed; one said "There are not enough staff at certain times". Another member of staff said "We use a lot of agency, virtually every shift, it makes permanent staff work harder and can be difficult". Other staff said "Staffing is adequate" and "Staffing is fine at the moment". A final member of staff said "We only had three carers the other day, we need more staff but it falls on deaf ears". There were times when people were put at risk when staff were not present. For example, in the Cherries unit lounge we observed a toaster being plugged into a socket which was turned on with no staff present. This meant there was a risk of a person causing an injury to themselves; there was also a risk of a fire being started.

The acting manager explained staffing levels were identified using a ratio of one care worker to every five people; they would also take account of short term needs, end of life needs or one-to-one requirements. The rotas demonstrated that they had maintained this level of staff. However, in a four week period the provider was unable to maintain their own set level of staffing on 26 days. To maintain the correct level of staff on these days agency staff were used. Additionally, other members of staff were being asked to complete extra shifts that had no cover. We spoke to the acting manager and operations manager who explained they were in the process of trialling new rotas for night staff because they had identified this was a time when more staff were needed. The acting manager also said there were long term plans for the provider to close another home and move the staff over.

One person said "I feel safe here". A relative said "I think it is reasonably safe" and a member of staff said "I feel the residents are safe here. I don't feel there are any residents unsafe or at risk, they all seem to be really happy." Staff told us, and records confirmed, that some staff received training in how to recognise and report abuse. Not all staff had received the training. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. One staff member said "I would report it to the nurse and manager, I would hope the manager would manage it, if not I would go to CQC". Another staff member said "I would report it to CQC if I needed to".

Inadequate

Is the service safe?

Recruitment procedures had been highlighted as an issue during a previous inspection as some staff had commenced employment before disclosure and barring clearance. Staff we spoke with said all pre-employment checks were in place prior to starting their role. Staff files for new staff showed that these procedures were now being followed, and appropriate safety checks were completed before people began working. This meant the provider was following the correct processes to keep people safe from new members of staff at the point of them starting work.

Requires improvement

Is the service effective?

Our findings

Staff did not have a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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. Most staff we spoke to were not sure what MCA or DoLS were. One said MCA was "Working around people's best interest when they can't make decisions, every day we try to enhance people's options"; others said they had not had training so did not know what it was.

Some people in the home were able to make decisions about what care or treatment they received. However, in both units people were living with dementia and complex needs This impacted upon their ability to make decisions on all aspects of their lives. Staff stated they offer choices regularly when including clothing, food, drinks, where people want to sit and which bathroom they would like to use. However, one care plan referred to the person as "unable to make decisions"; it mentioned a MCA which was not decision specific. It went on to say a best interest meeting had occurred, including the date and time this took place; no records could be found supporting this had happened. Another person had a behaviour that required checks of their bedroom. We were told by a member of staff they checked the bedroom when the person was not there; meaning the person was unaware of this action. There was no assessment completed under MCA to ensure this person did not have the capacity to consent to this infringement of their right to privacy and no decisions had been made in their best interest involving professionals and people who knew the person well.

Some people received medication covertly; this is when they were unaware of medicine being given because it is hidden in food or drink. When we spoke to staff about the administration of covert medicines, they did not demonstrate an understanding that MCA and best interest decisions should have been completed each time medicine was given covertly. This meant they did not have a good knowledge of their professional responsibilities as defined within the Nursing and Midwifery Council (NMC) Code 2015. The NMC is the body that regulates nurses and midwifes in the United Kingdom in order to protect the public and ensure minimum standards. The NMC says nurses should "Make sure you get properly informed consent and document it before carrying out any action"; the staff were not aware they should have done this. There was no record that an MCA and best interest decision had been held in relation to the covert medications for people that lacked capacity. The acting manager felt that mental capacity was considered in the home but it was not brilliantly written down.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The home had identified 30 people needing a DoLS application; 10 DoLS applications had been made to the local authority and one had been granted. No notification had been made to CQC about the granted DoLs. The acting manager stated they were prioritising applications dependant on whether people were displaying a desire to actively leave; also people who had previously been unable to leave due to other restrictions place upon them. They said that it was an ongoing process in the home and by the end of the week they should be just under half way through the DoLS applications. We found a discrepancy in one care plan that stated a DoLS application had been completed and granted; however, on further investigation it became apparent it had not been completed. The acting manager felt this could have been a typing error although it was recorded in two separate places in the care plan. As a result of not completing DoLS applications for all people that required them or following the MCA process the provider was at risk of breaching people's human rights even if they were trying to keep them safe or make appropriate decisions.

This is a breach in Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were at risk of not receiving effective care and support from staff. Some staff were positive about the training opportunities that they were given. One staff

Is the service effective?

member said "If there is training I want to do that is not on the list they would support me". Another staff member said "We receive a lot of training, its pretty good". Staff members explained the benefit of the Butterfly Project and the training this included. In contrast, one staff member said "I was booked on some training, but then it got cancelled". Another member of staff said "I would like training updates on a lot of things to have support with my competencies but training is often cancelled".

The provider's training matrix did not correlate with the evidence of training within staff files, and there were significant gaps noted. Following the inspection the provider told us dementia training was not added to staff files because it was part of the whole home accreditation with the Butterfly Project. According to the training matrix 46 out 60 members of staff had not completed training in mental capacity and deprivation of liberty. This lack of training and understanding may have contributed to the issues in relation to safe medicines administration and was also evidenced in the way consent to care was documented within care plans. For example, of the four permanent qualified nurses on duty throughout the inspection, only two had completed mental capacity training. The nurses were responsible for writing and amending people's care plans. Due to the lack of training one person's care plan documented that "[A named person] has been assessed as unable to make informed decisions". However, in the same plan it was documented that "[The same named person] has consented to receive ongoing care". Another plan stated "[A named person] has consented to care" but this was then contradicted as staff had also documented they were "Unable to give consent and an advocate is required". It was not clear whether the person had been assessed as having capacity to consent or not, or whether an advocate had been sought to assist with the process. The acting manager thought that all the staff that had worked for the home for a while had received training in MCA and DoLS because the registered manager was the provider's trainer for this. They thought time might have had an impact on the training being delivered by the registered manager for newer staff.

Members of staff we spoke with confirmed they had not received training in pressure care. We spoke to the registered manager about the lack of training around pressure care for the wound management nurse on each unit. The registered manager advised that no training was provided for those that needed it but they had awareness of available training The training matrix showed no nurses had received training on pressure care; as a result, people were at risk of developing pressure wounds and not having them treated correctly. Other examples of gaps in training included a staff member who had been in post since 2014 and had not completed training in infection control, first aid or mental capacity. Another staff member was overdue a moving and handling update. The training matrix showed that 20 members of staff had not received safeguarding training. This meant there was a failure to ensure all staff received training to ensure they had the knowledge to perform their role and responsibilities effectively.

Staff had mixed views about supervision. Some staff said "You get constructive feedback, they check you understanding, we recently had a supervision where we discussed end of life care" and "You look at set topics and anything I want to raise, they are two way and constructive". Another member of staff said they did receive supervision with regard to their work but it was not on a regular basis. Staff supervision sessions were not taking place as frequently as the provider's policy stated. The policy stated every six to eight weeks, but this was not reflected within the staff files. Of the nine staff files we looked at, seven staff were on duty during our inspection and two of these had received supervision sessions during 2015. Although staff had been allocated a supervisor recently, supervisions were not taking place as often as they should and there was no system to ensure staff had their supervisions booked regularly. Two of the files we looked at contained appraisal documentation, but these related to appraisals that had taken place during 2010 and 2011. There was no documentation in relation to appraisals for 2015. We spoke to the acting manager who said they had only carried out the appraisals for two members of staff since they had been actively involved in the home. By not providing regular supervisions and appraisal for staff they were unable to identify if staff had received appropriate support, training and professional development to enable them to carry out their duties.

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

People ate their lunch in the dining room and lounge or in their own rooms. The lunchtime experience was varied. One person said "Sometimes the food is acceptable and other times not, but I have always been fussy about my food." Another person said "The food has improved since

Requires improvement

Is the service effective?

six months ago – [the acting manager] sorted it out." A relative said "The food is quite a good standard." A member of staff said "We just don't pick a meal we give options, we use visual plates and people point to what they want." In the Elms unit we were shown a list where people made a choice about what food they would like the next day. It identified whether the food was prepared in a special way; for example, pureed. There was always a choice of meat or fish available; there were other options such as beans, eggs and jacket potato if they did not want the meals. We saw a person leaving their main meal and being offered different options. There was always a choice of one main pudding then yoghurts and ice creams as additional options.

In the Cherries unit there were two hot meal choices on offer and people were offered a choice visually. We saw a staff member supporting a person with their meal; the person had their meal prepared to the required consistency. The staff member told the person what their meal was and asked if that was ok. Throughout the meal the staff member was checking with the person and telling them what they are eating. However, another person was not supported with as much care; there was little communication with the person and no choices were offered.

The home arranged for people to see health and social care professionals according to their individual needs. One person told us a doctor had visited them about a specific health condition. Another person had it recorded in their daily records a visit from a community health and social care professional. This meant that people had access to other health and social care professionals when it was required.

Requires improvement

Is the service caring?

Our findings

Some people said they were supported by kind and caring staff, but there were times when this was not the case. One person said "I am very happy here, they are very kind". Another person said "I am happy with my care and the regular carers, all the [regular] staff are good and I trust them"; however, this person continued by saying agency staff were a mix of good and not. A relative said staff are "Very kind and deal with things very well." A member of staff said "You can tell if people are happy, if someone isn't you find out why, make them feel comfortable."

We saw caring interactions between staff and people. On one occasion a person was becoming distressed about when lunch was going to happen; a member of staff established they wanted to prepare some potatoes so got them a peeler, potatoes and a bowl. Another time a person became angry and distressed that another person had sat in a specific place in the lounge. A member of staff knelt down, and explained calmly why it was ok for the person to sit where they were. They did not patronise them, or raise their voice; they spoke quietly and calmly and the situation was quickly resolved.

However, there were times when staff interactions were not as positive. At a meal time we saw one person being supported with no interaction from the staff member helping them; the staff member did not communicate when they put an apron on them or when they spooned food into their mouth. A person became anxious when a member of staff was disagreeing with them about something; once the staff member realised how anxious their actions had made the person they changed their approach. Another staff member was seen saying loudly to a person, in front of others, they had a runny nose; this was not showing them respect.

People's privacy was not always respected but all personal care was provided in private. Some people told us they were able to manage their own personal care. We saw other people being supported in a caring and dignified way; staff were informing the people what they were doing and ensuring the person was alright. People who required equipment to help them in transfers were given reassurance and staff talked through what was happening. However, there were times we saw staff entering people's bedrooms without knocking; when one member of staff did this they still greeted the person by saying hello. This meant that there were occasions that people's privacy was not respected by staff.

People were able to have visitors at any time; each person who lived at the home had a single room where they were able to see personal or professional visitors in private. Also, people could use other quiet spaces around the home to see their visitors. Two people told us about relatives coming to the home and taking their loved ones out for walks or drives. However, one relative told us that visitors could just walk into the home without being asked who they were. Following the inspection the provider told us they have a keypad entrance system to the home, signing in books and a receptionist to the home.

People made choices about where they wished to spend their time. One person said "I have my breakfast in bed and I eventually end up coming down. I could stay in my room if I wanted to." Another person said "I am allowed to eat it where I like." In one lounge area where music was playing, staff asked "Does everyone like this music or would you like me to change it?" We also saw staff sitting with people, reading them the paper, and talking about their families. A member of staff said "families are always asked to be involved in the decisions" they also said, "residents are encouraged to choose their own decoration. We like to involve them". There was evidence of different personalised decorations in the bedrooms, seen alongside personal effects.

In the Cherries unit, some people were unable to communicate verbally with the staff to express their choices. We spoke to staff about how they help these people to make choices; a staff member described how they do this when people appear to be unhappy. They said "We write things down, use an Etch-a-Sketch, picture and facial expressions". Another staff member said they were aware of one person who communicated by using facial expression, raised eyebrows to demonstrate they like something and frown to demonstrate dislike.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. This meant they were respecting people that they were caring for and respected their privacy.

Requires improvement

Is the service responsive?

Our findings

Not all people received care that was responsive to their needs and personalised to their wishes and preferences. People were not always engaged in activities of their choice or that reflected their needs. A person said "I don't go to the activities at all now, just the pub. The types of activities are not for me". Another person said "The staff take out some of the residents - not that often". Two people told us about activities including visiting a garden centre and going out for a cream tea; one of them said "They tell us not to tell others where we have been". They explained this was because staff knew they were unable to take everyone out. A visitor said "The [staff] just don't have time for activities" and a relative said "[My relative] has not left the building since New Year".

In the Elm's unit there was an activities board with a list of four which took place in September; in October and November no activities were recorded. The activities in September were keyboard playing/ guitar singing/ flower arranging/ church service. Any other activities were one-to-ones or major celebrations. For example, Christmas, when singers were being arranged to come in. In the Cherries unit downstairs in the lounge there was lots of positive interaction. However, upstairs we observed little interaction with people in their bedrooms, particularly in the morning. One person was sat in their chair vocalising, staff said they liked to have their hand held; we did not see them doing this.

There were two activity coordinators; one explained they still spent some of their week at another home. Both activity coordinators told us how they tried to organise more activities for people; they were restricted by resources including a lack of transport. They had recently sourced community transport because concerns had been raised about their own transport being out of action. People still had a lack of opportunities despite sourcing new transport options. The residents and relatives meeting from September 2015 said "All outings have to be on a rotational basis to allow all residents to be offered a trip during the year." Following the inspection the provider told us the transport is offered on a rotational basis because it is not included as a normal service. This meant not all people were provided with appropriate activities to meet their needs and reflect their preferences. Some of the computerised care plans had limited information on reflected people's wishes and hobbies so activities were not always reflecting them.

Care plans were not always personalised to each individual and lacked information to assist staff to provide care in a manner that respected their wishes. The provider was using an electronic care planning system; to access these each unit had one laptop and one computer. Staff said there was not enough time or computers to update the plans or read them. The acting manager explained there should not be a queue for the computers, but said the culture around paperwork needed to change. The quality of care plans was variable, and they were not always person centred or contained important details. It appeared that the system generated statements based on the information that staff put into the document; this meant several plans contained the same statements meaning they were not person centred. Plans for people living with dementia contained the same statements on how to care for them, such as removing mirrors from bedrooms. Care plans had similar, generic statements for the needs around decision making including mental capacity.

The care plans were not always reflective of people's current care needs and three people had no care plans despite the provider's policy saying they should. A member of staff explained that during the handovers between shifts the information was passed over for these people and there was a daily report book outlining any changes. In the medication section of one person's plan staff had documented "Usual medication routine"; yet handwritten records informed staff the person was currently experiencing difficulties taking their medicines. The person also had specific needs around drinking; this was not documented within the care plan. Another person had a significant change in their needs that could affect staff. There was only a general statement about this; we asked a member of staff who was unaware of these changes. We spoke to the registered manager and acting manager who said the information had been passed on during staff handovers for four or five days; the member of staff was not always working at this home. Due to high levels of agency staff people's needs would not be met if they had not been at the handovers because there was a poor amount of information or accessibility of the care plans. This placed people at risk of receiving inappropriate care that did not reflect their needs or preferences.

Requires improvement

Is the service responsive?

While some of the plans contained details of people's preferences this was not consistent and some contained no information. There was no formal method of involving people in their care plans. A member of staff said "We talk to people, explain to them and ask if they are happy, ask them what they would like". Staff said they were made aware of peoples changing needs through handover which is held twice a day. There was a handover documents in place which were used to record significant information. Another member of staff said "I would report a change in need to the nurse; handovers are used to communicate changes in need".

Wound care plans were not easy to access for staff due to the limited computers on each unit; they did not always contain up to date dressing details or photographs. Staff said "It's not easy to find the details, but the system is new and we are still learning". There were no online records for people that needed pressure wound prevention plans identified or risk assessments in the online records; we found some in old paper notes but these had not been reviewed for over six months. In the space of a month, one person had developed a pressure wound. Although the wound care plan was in place, there was no photograph within the plan to indicate if the wound healing process was working or if the wound was deteriorating. People were at risk of health needs not being met and in danger of harm because care plans were not accurate or up to date.

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

There was a complaints system in place at the home. One person said "I would definitely go to the Manager if things weren't right." A relative said that they were not sure what the complaints system was but they may have been told at the beginning. They went onto explain that due to the nature of their loved one coming to the home they had forgotten lots from that time. When one member of staff was asked how they supported people to raise concerns they said, "I would see if they are happy to talk to me if not I would encourage them to speak to the manager, if it was a safeguarding I would go to the manager". We saw three complaints had been raised at the home; these had been investigated and responded to appropriately. There had also been one complement received by the home.

Inadequate

Is the service well-led?

Our findings

The home was not well led because the management arrangements had not ensured the service was well run in the absence of the registered manager. The registered manager had been absent from the home for a continuous period over 28-days. The provider told us there had been a change in management structure at the home; CQC had not been notified about this. The registered manager, acting manager and operations manager told us the last time the registered manager was on site was three months ago to train a senior member of staff in DoLS applications. The registered manager said they had been acting as a consultant manager for other homes belonging to the provider. CQC should have been notified prior to these changes occurring including the length of time that it was for, the details of who would be managing the home in their absence and the reason for absence. Because CQC was unaware of the changes we were unable to monitor the effect it had on the people living in the home.

This is a breach in Regulation 14 Care Quality Commission (Registration) Regulations 2009.

The provider by law must notify CQC about certain incidents. This includes any DoLS application that has been authorised. The provider had not informed us of the one that had been granted. This means CQC and other external bodies can monitor the management of incidents; it also ensures people using the service are safe and have their human rights protected.

This is a breach in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Systems and processes were not established or operated effectively to ensure people's health and social care needs were being identified and met. For example, there were no pressure care policies or procedures in place. This meant there was no clear guidance for staff about what they should be doing in relation to pressure care.

The policies and procedures for the home had been reviewed in March 2015 by the operations manager. Despite this the safeguarding policy was out of date because it contained old criminal record checking systems. It did not contain the most recent information about types of abuse. This meant that apart from the local authority safeguarding policy staff did not have an up to date policy and procedure to refer to when they required guidance. People were at risk of staff not following the best practice around safeguarding procedures to keep them safe.

There were few quality assurance systems in place to monitor care and plan on-going improvements. The registered manager showed us a monthly audit to analyse incidents and safeguarding. Some of the audits lacked action plans despite high numbers of incidents. There were no other up to date audits and checks in place to monitor safety and quality of care. The acting manager said they knew the audits were not up to date. They said they had done the infection control audit but knew it was out of date; they had not completed any other audit since starting work at the home. We saw evidence of some shortfalls in the service had been identified and action had been taken to improve practice around incidents; however, there was little recorded about the actions. Shortfalls found during the inspection had not been identified by either the registered manager, acting manager or operations manager.

The provider and managers had not ensured supervisions were being carried out in line with their own policies and procedures that stated they would occur every six to eight weeks. This meant staff were not receiving regular supervision and their training needs were not also being identified. Staff were not always receiving support from the provider to be able to carry out the role they were employed for.

The quality assurance systems had not identified shortfalls in risks and subsequently the managers and provider were not mitigating risks to the health, safety and welfare of people. Incidents around medication and a lack of assessments in pressure care increased risks to people because the management had not identified them in their monthly audits. The systems around incidents had not demonstrated effective debriefs for staff members injured whilst at work. Following an incident a member of staff had two conversations with the acting manager to get the correct medical treatment; they confirmed there had not been a debrief about the incident. The staff member continued to say they had two conversations to get the correct medical treatment. People and staff were being placed at unnecessary risk because the management were not always taking appropriate actions following incidents.

Inadequate

Is the service well-led?

There were not accurate and complete records for each person; some of the care plans had general phrases rather than person specific due to the electronic systems. The use of high levels of agency staff increased the risk to people further because care plans were not specific to people's wishes or needs. As a result of minimal monitoring by the management and provider, information required to keep people and staff safe had not been recorded accurately. People's human rights were at risk of being breached as processes to ensure their best interest and capacity were not being followed. We spoke to the acting manager who said they needed to evaluate the use of the new electronic system moving forward. They had been using the system at a smaller home but were unaware of how transferable it was into a large home.

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

The culture of the home was not clear; the Cherries unit had a strong emphasis towards the Butterfly approach which was person led. In contrast, in the Elms unit we observed interactions were caring but more task-based. When describing the Elms unit, a relative said it was "More of an institution than a care home." A member of staff said "There are different cultures on each unit, and it shouldn't be like that. Staff on The Elms don't want to work on Cherries and vice versa". The acting manager explained that the home had made a good start with the Butterfly approach but it needed to go further. It was explained that historically the two units had different managers but they wanted to embed the culture across both units. There were staff meetings occurring to communicate the plans to staff members. The acting manager was aware the new culture would not suit everyone's personality and was aware that some staff would leave. They wanted everyone to be on board with the Butterfly approach.

Most staff were positive about the acting manager; a member of staff said "The manager [meaning the acting manager] is easily accessible and approachable". Another staff member said "The manager [meaning acting manager] is here all the time is very accessible and helps out now and then they are part of the team". The acting manager made it clear that if she needed to be active and hands on then they would. The registered manager explained that they were able to monitor the home through phone calls and looking at the quality assurance questionnaires. We asked to see evidence of the analysis they had undertaken but this was not provided.

The acting manager was a registered nurse and they kept their skills and knowledge up to date by on-going training and reading. They explained they attended providers meetings and registered manager forums to keep up to date with latest developments. The acting manager explained they completed study days and received journals. As part of the Butterfly project they had completed a dementia certificate and they attended some recent training around the process for new induction for staff.