Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Saltshouse Haven Residential and Nursing Home

Inspection report

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Date of inspection visit: 21 and 24 September 2015.
A further two out of hour's visits were undertaken on the 2 and 7 October 2015
Date of publication: 23/11/2015

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?	Inadequate
Is the service well-led?	Requires improvement

Overall summary

Saltshouse Haven is registered with the Care Quality Commission [CQC] to provide care and accommodation for a maximum of 150 people who have nursing needs or may be living with dementia. The location is separated into five independent units across the site. It is located on the outskirts of Hull and has good public transport access. It is close to local shops and other amenities.

The inspection was unannounced and took place on 21 and 24 September 2015. A further two out of hour's visits were undertaken on the 2 and 7 October 2015, these were also unannounced. The service was last inspected in November 2014 and was found to be compliant with the regulations inspected at that time.

At the time of the inspection 114 people were living at the service.

This service does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager was in place at the time of our inspection and they were in the process of applying to become registered with the Commission. We have called them the interim manager throughout this report.

Due to the level of risk and concerns found during the inspection, the registered provider has agreed with the CQC to a voluntary suspension on further admissions to the service. This will stay in place until we are satisfied people are no longer at risk. The local authority has also suspended placements. Other local health care providers have also taken the view that people are at risk and have suspended placements.

We found the registered provider was in breach of seven regulations of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. The breaches included staffing, providing person-centred care, safe care and treatment, need for consent, handling complaints, dignity and monitoring the quality of the service. You can see what actions we have told the registered provider to take at the end of this report.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'special measures' by the CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months of the publication date of this report. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. to begin the process of preventing the registered provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Inadequate staffing levels impacted on the quality of the care people received and on their quality of life. Monitoring charts and other important documentation was not completed and people did not receive the care they needed to keep them healthy and promote their wellbeing. People who used the service did not always receive care and treatment which met their needs or was person-centred. People did not always receive their medicines as prescribed by their GP. People were not consulted about their care and did not always have the opportunity to be involved with their care and treatment. People's consent was not always obtained. There was a lack systems which ensured decisions were in people's best interest. This meant people were at risk of receiving care which was not of their choosing, met their needs or protected them from harm.

People did not have the opportunity to participate in meaningful activities or access the community when they wished. People's privacy and dignity was not always respected and doors were left open while people were in their beds in various stages of undress. Complaints were not recorded or dealt with effectively and no audit of complaints had been undertaken to identify trends or patterns so practise could be changed or addressed.

Audits which had been undertaken had failed to identify the issues which affected people's quality of care and quality of life highlighted during the inspection. This meant people lived in a service which was not well-led and was not flexible and adaptable to meet their needs.

People were provided with a varied and wholesome diet which was monitored and health care professionals were consulted when needed. However, the choices shown on the menu were not always the meals provided to people.

Summary of findings

Staff received training which equipped them to meet the needs of the people who used the service and this was updated when required. Staff understood how to report any abuse they may witness and had received training in how to identify the signs and symptoms of abuse.

You can see what actions we have told the registered provider to take at the end of this report.

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 were not safe.

Staff were not provided in enough numbers to meet the needs of the people who used the service.

People's medicines were not administered as prescribed.

Staff were recruited safely.

Staff were aware of what constituted abuse and how to report this.

Is the service effective?

Requires improvement

Some areas of the service were not effective.

Staff did not apply or adhere to the principles of the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS].

People were provided with a wholesome and nutritious diet but this was not always of their choosing.

People's health care needs were not met.

Staff received training which was relevant to their role.

Is the service caring?

Requires improvement

Some areas of the service were not caring.

We observed staff had a caring approach but people's privacy and dignity was not always respected.

People did not always have the opportunity to participate in discussions about their care.

Staff did not always fully understand the needs of the people who used the service.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive person-centred care and documentation did not reflect their needs or preferences.

People or their representatives were not included in decisions about their care and treatment.

Complaints were not recorded or resolved to the person's satisfaction.

People were not provided with varied and appropriate activities to meet their needs.

Summary of findings

Is the service well-led?

Some areas of the service were not well-led.

Systems were not in place which ensured people received the care and treatment which met their needs.

Effective systems were not in place to ensure there were enough staff on duty at all times to meet people's needs.

Systems were not in place to ensure people received their medicines as prescribed.

People who used the service and other stakeholders were consulted about the running of the service.

Requires improvement

Saltshouse Haven Residential and 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 registered 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 21 and 24 September 2015 and was unannounced. The inspection was completed by two adult social care inspectors, two specialist professional advisors and one 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 of the specialist professional advisors had experience of the care needs and welfare of people living with dementia. The other had experience of how to effectively manage infection control issues.

The local authority safeguarding and quality teams and the local NHS were contacted as part of the inspection, to ask them for their views on the service and whether they had any ongoing concerns. We also looked at the information we hold about the registered provider.

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 spoke with 20 people who used the service and 10 of their relatives who were visiting during the inspection. We observed how staff interacted with people who used the service and monitored how staff supported people throughout the day, including meal times.

We spoke with eight staff including nurses, senior care workers, care assistants, activities coordinators and domestic staff. We also spoke with the interim manager and the deputy manager.

We looked at 12 care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as incident and accident records and medication administration records [MARs]. We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

We looked at a selection of documentation relating to the management and running of the service. These included five staff recruitment files, training records, staff rotas, supervision records, minutes of meetings with staff and people who used the service, safeguarding records, quality assurance audits, maintenance of equipment records, cleaning schedules and menus. We also made a tour of the five units.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe, and if there were enough d-staff on duty. Comments included, “Yes, but sometimes there’s no staff about”, “Yes, staff are about”, “Yes, I have a nice room” and "Yes, I have bed rails to keep me safe.” One person said, “Good God no, it is disgraceful.” The person then went on to explain that most nights there were only two care assistants on duty.

Another person old us, “No, there are times when I have to wait for half an hour when I want the toilet.” They also told us, “If I use my call bell at dinner time they say I have to wait as they are busy and it can be over an hour.” They described how they felt embarrassed if they soiled themselves due to having to wait for staff assistance. Another person told us they lived with their partner at the service and they press the call bell when their partner needs the toilet; they told us they have waited for up to 25 minutes for the staff to attend. They went on to describe how on one occasion the staff hadn’t come so the person had taken their partner to the toilet themselves and they had fallen in the toilet. Staff had come immediately but they had been shaken by the experience. The incident had been recorded in the person’s care plan but not the reasons why it had happened.

We asked visitors if there was sufficient numbers of staff. Comments included, “No, not enough at night, only two staff on”, “Call bells can take between 10 to 30 minutes for a response.” One visitor told us, “[Person’s name] had waited but when no staff came they got out of bed and slid on the floor.” Another visitor told us, "Frequently no, the problem is mainly at night, there are usually only two staff on and a senior has to come from another unit.”

Staff told us of their dissatisfaction with their working conditions and the expectation to work long hours. A number of staff told us they intended to leave as they found the conditions they worked under intolerable. They told us they often stayed behind after their shift had ended to ensure documentation was up to date. Other member of staff told us of their frustration at not being able to meet people’s needs and constantly telling them to wait. One member of staff said, “I would hate it if my mother was in here, we just do not have the time to care for them properly.” Another said, “Sometimes there is only one nurse on in the morning and then it is really difficult. There are 25 service users all on a lot of meds and all high needs. We’re short staffed usually every day.” Another said, “At times I feel we are very pushed with regard to staff numbers as some of the people could be quite challenging.”

We saw there had been a lot of unwitnessed falls with people found on bedroom and bathroom floors; staff recorded they had not witnessed what had happened. The staff then took appropriate action and sought medical attention, however they were unclear about how long the person had been on the floor or when the accident had happened. The interim manager had recorded these accidents but had not identified there had been a large number of unwitnessed falls which may be attributed to lack of supervision and staff monitoring.

Rotas we looked at indicated the numbers of staff which should be on duty but in reality this was seldom the case. For example, on all of the units there should be three members of night staff on duty; however staff told us they often worked with two care staff on duty and had to call on other units to cover the short fall. Staff were also expected to cover on other units if there was a shortfall. For example, one person’s notes showed that a member of staff from another unit had been called to help with medicines; people who used the service had to wait for over an hour for their medicines until the staff member was available to administer them.

People were also at risk as many needed two staff to assist them therefore leaving the others unsupervised. We saw an example of this during our inspection as staff were being moved around units to cover for staff shortfalls.

We found that one of the people who used the service had to go to bed after lunch when their relatives left as they were at risk of falling as they constantly tried to stand unaided. Staff told us they undertook this practise because, due to staffing levels, it was the safest option.

Two of the units provided a service for people who were living with dementia. We saw these units were very busy and on one of the units, three people were receiving one to one care funded by the local authority due to the risk to themselves and others. We found that senior and qualified staff were undertaking the morning medicines administration until lunch time due to interruptions and the expectation to manage the unit. This meant people did not receive their medicines as prescribed and times had to be changed.

Inadequate

Is the service safe?

We also saw from documentation we looked at, people were not receiving the care and attention they required. For example, people's turn charts showed large gaps in recording. One care plan we looked at indicated the person should be turned every four hours but we found there had been long interval between turns, for example between five and 11 hours. Staff we spoke with confirmed this was the case as they were short staffed and could not provide the four-hourly turns the person needed. There were also gaps in people's fluid charts. For example, one person's fluid chart showed they had received 495mls on 14 September 2015, 280mls on the 16 September 2015 , 300mls on 20 September 2015 and 525mls on 21 September 2015. We were unsure if the person had received adequate fluids or if this was a recording issue by staff. People's dressings were not being changed regularly. For example, one person did not have their leg dressing changed until eight in the evening and their care plans showed this should have been done in the morning.

We observed one person shouting frequently throughout the day and staff trying to reassure them. This worked for a while but they started shouting again. This upset the other people who used the service and we heard one person shout, "Shut up or I'll be over to sort you out." Staff were not always there to protect people and to prevent harm.

During the inspection a nurse, who was visiting the service to assess the needs of specific people who were funded as part of the continuing health care service, told us of an instance when they had been the only qualified nurse on the nursing unit. They had to support staff caring for a person who was receiving end of life care, and their family, as the qualified nurse on duty was helping out at another unit due to a shortage of staff.

During an out of hours visit, it was found agency staff had been used to cover the short fall on the dementia unit and they did not have the skills or the knowledge to care for people living with dementia. We also found there was no senior care staff on duty on the dementia unit so staff had to be used from another unit to administer medicines to people.

Not having sufficient staff on duty at all times with the right skills and experience is breach of regulation 18 [1] Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We observed the medicine round on one of the units and this took until 11.15am. The member of staff undertaking this told us they had started at 08:30. They told us there were a lot of people they had to try and persuade to take their medicines and this may take a few attempts. Staff told us there were lots of distractions when administering medicines; they gave examples of phone calls, carers wanted them to look at things, incidents they have to intervene in and visitors wanting to speak to them. They told us, "Protected times and protected phone calls don't work." We did not see any record on each person's medication administration record [MAR] of what time the medicines were eventually given. It would be good practise to record the times medicines are actually given so the correct time can elapse before the next does is given.

We looked at the MARs of all the people on three of the units. On one of the units there were 10 signature gaps in a three week period. Staff had transcribed someone's medicines onto the MAR and this only had one signature. This is not good practise as two signatures demonstrate there has been a check, ensures the information has been transcribed correctly and there are no mistakes. We found one person had not had a prescribed medication for one week as it was not in stock. On both units there were a number of MARs with no photographs of the people who used the service. We found there had been lots of refusals to take medicines but there had been no assessment of this and advice sought from GPs or consultation as to whether the medicines needed to be administered covertly. We found there had been occasions when people who used the service had refused medicines in the morning but staff had not tried again later.

We found the controlled drugs [CD] register on one of the units was not fit for purpose and pages were falling out. This is a document that is required by law and must be in a good state of repair and show a full and comprehensive audit trail. We found there had been a missed second signature for one medicine in the CD register.

We found that some instructions on the protocols for 'as and when required' [PRN] medicines didn't match instructions on the MAR. This may give conflicting guidance to staff and result in medicines not being administered as prescribed. We also found that when staff were administering PRN medicines they were not recording on the MAR the reasons why the medicines had been administered or how successful the medicines were. This

would be useful information to use as part of the ongoing assessment of the effectiveness of the medicines in meeting the person's needs or keeping them and others safe. We found one person had run out of paracetamol prescribed for pain relief. Staff had recorded that they had been asked if they wanted pain relief and the person had said yes but staff then couldn't find any to give them.

We found that another person had been prescribed a topical cream to be applied thinly for one week but they had received this for 13 days to date. We found that one person had been prescribed an opiate based pain killer before their leg dressings were changed, however records showed they did not get this and consequently experienced pain.

One person had been prescribed a medicine to be taken three times a day when required for agitation but it was noted they had this every night at 6pm. Staff told us their relative said this was when they always had it. We found no evidence of a medicines review with the person's GP to change this prescription to one that met their needs.

We found there was inconsistency between the units in the way medicines were recorded, for example some staff were not using codes consistently on the MAR chart.

People did not always receive their medicines as prescribed and they were not always recorded and managed effectively. This is breach of Regulation 12 [2] [g] Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We observed good practise when staff administered medicines. Staff provided explanations of what medicines were for, offered drinks, waited for people to take them and then signed the MAR. They locked the trolleys up when they left them to administer medicines. Both units had separate rooms to store trolleys and medicines. Each room contained two sinks, a store cupboard and a controlled drugs cupboard. Staff recorded fridge and room temperatures and these were up to date. Destruction kits for medicines were in place. We also saw instructions for the administration of specific medicines were held with MAR to give staff up to date information. There were body maps for CD patches so this could evidence rotation of site. We saw the service obtained photocopies of prescriptions to aid checking what was delivered was correct.

All staff we spoke with were able to describe the registered provider's policy and procedure for the reporting of any abuse they may become aware of or witness. They told us they received training about what abuse is and how to recognise the signs of abuse, for example, bruising and a change in mood. They were aware they could approach other agencies to report any abuse; this included the local authority and the Care Quality Commission. We looked at training records which confirmed staff received training about how to safeguard adults from abuse and this was updated annually. There was a record of all safeguarding incidents and the outcomes.

People's care plans showed risk assessments had been carried out when they had been admitted to the service, however these were not always up to date. Risk assessments had not been completed consistently, particularly those carried out for the risk of people contracting a communicable disease or the use of bed rails to keep people safe. People had been assessed as requiring intervention to prevent the risk of tissue break down, malnutrition and dehydration. However, documentation we looked at had not always been completed correctly, for example we found gaps in turn charts and fluid monitoring charts.

The premises had been audited and areas of risk had been identified. For example, any repairs were undertaken by the registered provider's maintenance team and the units were monitored on a daily basis by the managers of each unit. Any equipment found to be broken or no longer fit for purpose was repaired or replaced. However, we did find that some of the fire exits had been compromised due the storage of furniture, beds and wheelchairs. This was pointed to the interim manager during the inspection and items were removed.

We found staff were recruited safely. We looked at the recruitment files of recently recruited staff. We saw these contained references from previous employers, an application form which covered gaps in employment and experience, a check with the Disclosure and Barring Service [DBS], a job description and terms and conditions of employment.

We had received information prior to the inspection that three people had contracted C. difficile. This had prompted Public Health England to intervene as this was a high instance of cases in one area; as a result the service had taken the decision to close to further admissions. We also found the service had cooperated with other health care professionals to look at how this could have happened.

Inadequate

Is the service safe?

There had been correspondence forwarded to GPs at the time of the incident advising them of the need to review antibiotic use. We found evidence of good practise adopted by staff in the treatment and containment of the outbreak; this included using the appropriate hand washing techniques and cleaning solutions. There were good supplies of alcohol hand rub, hand soap and paper towels and it was noted that staff were undertaking hand decontamination at appropriate times, for example after removal of gloves and prior to serving meals.

The laundry was tidy with identified clean and dirty areas in order to prevent cross infection. Clean laundry was correctly stored and equipment was clean. Laundry staff told us they had access to equipment to prevent the spread of infection, for example red bags for soiled linen. Bathrooms, toilets, store cupboards and sluice areas were clean and tidy as were hoists and commodes. Staff told us mattresses were checked on a monthly basis and we found the environment was clean and tidy and there was no unpleasant odours.

Requires improvement

Is the service effective?

Our findings

We asked people if they thought staff were sufficiently skilled and experienced to care and support them. Comments included, "They seem to know how to look after me." We asked people who used the service if they had the opportunity to make decisions and choices about their lives. Comments included, "Nobody tells me what to do", "I get up at 6am and go to bed at 11pm but I am always getting told that I have to wait." People's comments were varied about the meals. These included, "Overloaded with salt, too salty, no choice at all at lunchtime they just bring a tray. But I get lots of drinks", "The food is good, plenty to eat and lots of drinks", "I get plenty, not bad at all and I get choices and my daughter fetches me fruit juices" and "The food is always cold."

We asked visitors if they were involved in decisions about the care of their relative. Comments included, "Yes, they always ask and keep me informed." Others told us the staff contacted their relative's GP or district nurse when needed. Comments included, "Yes [relative's name] has seen one, district nurses come to do her medications" and "If a doctor is here when I visit they ask me if I want to speak to him." Visitors told us they were concerned at the lack of knowledge of the agency staff who were used to cover staffing shortfalls. One visitor told us, "The new staff are not trained to manage a stoma. The manager sent in two staff to change my wife's stoma but they just ripped the adhesive off causing her pain and to cry out. They should have used a spray to release the adhesive. I had to show them what to do."

We asked visitors if their relatives' had any special dietary needs and were these met. Comments included, "[Relative's name] is a diabetic and has allergies; we gave them a list of what they can have. There have been odd times they have brought food they can't have but 99% of the time it is fine", "Yes, she has textured food to help her swallow" and "[Relatives name] has a normal diet, he tells us he enjoys the food."

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS]. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. We found two people were given their medicines covertly. One had documentation in their care plan that a meeting had taken place with the GP and it was felt that in the person's best Interests that the medicines should be given covertly. However, we could find no mental capacity assessment or best interest decision paperwork to support this. For the other person receiving their medicines covertly there was no reference to it in their care plan, only on their medicine administration record. It was clear that the Mental Capacity Act was not fully understood and assessments in the care plans looked at were generalised and not decision specific.

Of the people who had a 'do not attempt cardio pulmonary resuscitation' [DNACPR] agreement in place none had capacity assessments or best interest decisions, though it clearly stated on the forms they did not have capacity. We saw one person who was trying to leave one of the units. We were told this was a regular occurrence, however, we could find no evidence of mental capacity assessments or best interest decisions in that person's care plan. Staff told us they tried to distract the person from leaving and offered them a cup of tea. The interim manager was undertaking a DOLs application for the person and there were other applications they were in the process of completing.

People's consent was not always obtained. There was a lack systems which ensured decisions were in people's best interest. This meant people were at risk of receiving care which was not of their choosing, met their needs or protected them from harm. This is a breach of Regulation 11 [1] Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Staff told us they received training which equipped them to meet the needs of the people who used the service. They told us some training was updated annually which included health and safety, moving and handling, fire training and safeguarding vulnerable adults. We saw all staff training was recorded and there was system in place which ensured staff received refresher courses when required. Staff also told us they had the opportunity to further their development by undertaking nationally recognised qualifications. They told us they could undertake specific training, for example dementia and how to support people who displayed behaviours which challenged the service. Induction training was provided for all new staff; their competence was assessed and they had to complete units of learning before moving on to new subjects. New staff shadowed experienced staff until they had completed their induction and had been assessed as being competent.

Requires improvement

Is the service effective?

Staff told us they received supervision on a regular basis and also received an annual appraisal; we saw records which confirmed this. The supervision session afforded the staff the opportunity to discuss any work related issues and to look at their practise and performance. Staff told us they could approach the interim manager at any time to discuss issues they may have or to ask for advice. The staff's annual appraisals were held to set targets and goals for the coming year with regard to their training and development.

During the inspection we spoke with an 'Admiral Nurse', employed by BUPA to support a number of homes in Dementia Care. They told us they ran a monthly dementia clinic in which problems can be discussed; they looked at Key Performance Indicators which showed whether training and Behaviour Support Plans were reducing the incidents at the service. They also monitored the use of anti-psychotic medication administered to people to help manage their anxieties.

We observed the lunch time experience on three of the units. Menus were displayed around each of the units. These told people what there was available to eat and what the meal of the day consisted of. However, on one of the days of the inspection, the menus on the tables showed the main meal to be a choice of shepherd's pie or baked fish. However, when the food arrived there was neither of those choices available and people were offered steak pie or roast chicken breast. No one we spoke with could remember being asked for their choice of meal and was not disappointed with the food on offer. The food looked wholesome and people were offered more if they wanted it.

Observation on the dementia unit showed the meal time was chaotic with people being served their meals either in their chairs or while they were walking around. The staff served people in the dining room first then served those who remained in their bedrooms. Visitors were helping their relatives to eat. One visitor said, "I'm sure they wouldn't eat if we didn't help the staff."

On another unit, all the people were well supported. One person was communicated with using a note book; the unit manager confirmed they had ordered flash cards for them as they were living with impaired hearing and were also struggling to see. We did not see any specialised cutlery or plates set out at the beginning of the meal, however half way through lunch staff did put on a raised plate side for one person. People were asked if they wanted their food cutting up and this was done. Choices of drinks were provided including water, juice and tea. Puddings were provided but no choice was offered to people.

Contact with health care professionals was recorded in people's care plans and during the inspection we saw district nurses, GPs and other health care professionals visiting the service. We looked at people's wound care plans; we found that one of these plans did not have what the person's dressing was. We found there had been some delays in reassessments of the wounds. For example, care plans stated wounds should be re assessed every three day and this had gone over by two or three days. Dressings were identified in the care plans, however, in one of them staff had added an additional protective dressing to surrounding skin but this was not in the person's dressing plan.

Requires improvement

Is the service caring?

Our findings

People we spoke with told us they felt the staff had the right approach and they cared about them. Comments included, “The vast majority of the staff do care about us.” People also told us staff encouraged them to be as independent as possible. Comments included, “Staff do help me but I am capable”, “Yes, they help me do things for myself” and “I don’t do much for myself so the staff help me a lot.” People told us they were involved with their care plans. Comments included, “It is all listed, anything I am unsure about I ask” and “No, I think they are very secretive.” People told us staff respected their privacy. One person said, “They knock, it is standard procedure.” People also told us the staff knew and understood their needs.

Visitors we spoke with told us they felt staff supported their relatives. One person told us, “[Relative’s name] is limited to what they can do; the staff always ask them and give them a lot of time.” Visitors told us their relatives did not always receive individualised care. One person said “They can’t because there is not enough staff on duty" another added “No, there is not enough staff to be able to do that.” Visitors told us they had observed staff respecting people’s privacy and dignity. Comments included, “The staff knock on the door before entering or they shout, and with personal care they are good” and “Yes, they always explain fully.”

Lots of the people who used the service were cared for in bed. However, on entering the nursing units we found bedroom doors to be open and people were laid in bed in various stages of undress. This compromised people’s dignity and did not respect their right privacy. This is a breach of regulation 10 [1] Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

All the interactions we saw between staff and people who used the service were positive. Staff’s knowledge of people’s needs was variable. When questioned they had some understanding of specific people’s needs and were able to show us ways in which they managed behaviours which challenged the service and put the person at risk. However, when we spoke with staff they did not have a full understanding of other people’s needs. For example, when asked about one of the people who used the service they could not tell us if they had a pressure ulcer prevention and management plan, despite the person being at the service for some time. We found this person had very little information in their care plans and staff said they could not tell us what was in them.

We observed people were treated in a caring manner and staff were kind and caring. Registered nurses, when questioned regarding the patient notes we reviewed, had in depth knowledge of the needs of those people which corresponded the documentation. One of the unit managers was very passionate about providing quality care to people and they wanted things to be good for them. On one of the dementia unit’s, staff had done a lot of work to make the environment more ‘dementia friendly’.

Staff told us they did not discriminate towards anyone due to their sexuality, race, disability or gender. Staff told us they had received training about none-discriminatory practise and they were aware the provider had policies and procedures in place to follow. Staff told us they cared for a married couple and they understood the importance of affording them privacy.

We saw very little evidence in people’s care plans of their involvement in its formulation and their agreement to care and treatment. The interim manager explained that the care plans were being rewritten and this was part of the ongoing development. We did see staff explaining what they were doing and how they wanted the person to help them. For example, they explained to the person how they were going to help them stand using a piece of equipment and reassured them. The person responded positively and cooperated with the staff.

Information was available for people about advocacy services and this would be facilitated if required. Staff understood the importance of respecting the confidently of the information they recorded about people’s needs and told us they would only share this with those who were authorised to see it. Files containing information about people’s needs were stored in lockable cupboards in the office on each unit.

Inadequate

Is the service responsive?

Our findings

People we spoke with told they knew how to make a complaint and who they would complain to. Comments included, “I would speak with the senior on duty, I wouldn’t have any hesitation”, “I never have any complaints apart from the lack of staff, but nothing changes” and “I would tell a carer, but I have no complaints as yet.” People told us they had confidence in the staff and comments included, “I think they would listen and do something.” We asked people if they got the care they needed and did they have choice and control over their care. One person said, “I don’t need too much, but they do help me if I need them.” Another person told us, “They do help me and ask me if I want things.”

We asked people if activities were available and if these suited their needs. Comments included, "We never do anything, my daughter takes me shopping occasionally”, “I have not done any”, “They have Bingo and I go if I want to. I have a lovely TV in my room” and “No, I stay in my room, but this is my choice.”

We asked visitors if they knew how to complain or express concerns. Comments included, “I would go to the unit manager or I would go to the office and have a word”, “I would tell the senior, if I was not satisfied I would see matron. I have been often to complain about the lack of staff, most people need two staff. They employed someone between 8pm and 10.30pm to help with bedding down but this only happened two or three times” and “I would see the manager or a senior, things are always explained.”

There was a complaint procedure in place and this was displayed around the service. We looked at the complaints file and could find no evidence of any of the concerns which had been expressed to us during the inspection being investigated or resolved. There was no record of any complaints about the staffing or the quality of the service despite people telling us they had raised this with the interim manager. We asked the interim manager to show us where they had recorded the complaints about the staffing and the service but they were unable to show us any records. People and other stakeholder’s complaints were not recorded or investigated. This is a breach of regulation 16 [1] Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Everyone at the service had a plan of care. This had been formulated from the assessments undertaken by the placing authority and the staff at the service. However, one care plan we looked at had not been fully completed and did not provide staff with a full picture of the person’s needs despite them being at the service for over a month. We found other files had not always been consistently completed. For example, one person received their nutrition through a tube directly into their stomach; however despite the service having a policy for the management of the device, there was no corresponding care plan. There was however reference to the device in the person’s daily notes. There was no care plan for the management of another person’s urinary catheter although there was reference to it in the daily update sheet and information about when the catheter was changed. A lack of care planning regarding the management of catheters including personal hygiene and the positioning of tubing could be a risk to the person as these devices pose a high infection risk.

We also found that due to the lack of staff, some people were not receiving care in person-centred way. For example, they had to wait to have their needs met and did not receive their medication on time. We found that not all of the care plans we looked at contained information about the person and their preferences. Care plans also lacked clarity about how the staff should care for the person and meet their needs. The care plans also lacked evidence of involvement of the person or their representative with its formulation or having an input into decisions made about their care and treatment. We found that one person had reverted back to their first language but their care plan did not state how this was to be managed or how the staff should communicate with them. We also found some care plans had not been reviewed for over three months. People did not always receive the care and attention to meet their needs. For example, monitoring charts were not always completed accurately. Dressings were not always applied as detailed in the wound care plan and people did not always receive their medicines as prescribed. People did not receive care which was person-centred, effectively met their needs or was of their choosing. This is a breach of regulation 9 Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We found that little or no activities were taking place during our inspection despite each unit employing an activities coordinator. We found that activities were not

Inadequate

Is the service responsive?

person-centred and tended to be undertaken in large groups. We found that no provision was made for those people who lived with dementia to participate in activities which met their needs and suited their preferences. We saw the activities coordinators helping the care staff to perform domestic duties, for example, serving lunches, helping with washing pots and serving drinks and snacks. When we asked staff about this they said it was attributed to the lack of staff on each unit and activities coordinators were used to cover the shortfall.

Requires improvement

Is the service well-led?

Our findings

We asked people who used the service if they felt there was a positive atmosphere at the home and did they feel involved with the running of the service. Comments included, "Certainly not, I want to leave here, I am hoping to go to another home when they have a room" and "I stay in my room, I don't get involved." We asked people if they had ever completed any surveys or given any kind of feedback on the home or taken part in any resident meetings; all told us they hadn't. We asked people if they felt the home was well-managed and if the interim manager and staff were always looking for ways to improve the service. Comments included, "No, I don't think so, they need more staff on particularly at night", "Yes, but I haven't been here long" and "It used to be lovely but it has gone off a bit."

We asked visitors if they felt there was a positive culture at the service and did they feel they could approach staff or the interim manager and get a positive response. Comments included, "Yes, that is one of the reasons why we brought dad here." We asked visitors if they had received a satisfaction survey and did they feel the service was continually looking for ways to improve. Comments included, "No, I didn't know that they had them", "I have been asked and I have attended a relative's meeting, I think they are twice a year" and "I have done a survey and I have attended a couple of relative's meetings." However, relatives told us they were not happy about the management of the service. However, we also received some negative comments about the way the service was managed. Five of the visitors spoken with told us they had been to the interim manager to complain about low staffing levels and nothing had changed.

Currently there is no registered manager in post. An interim manager is employed but has yet to complete their application for registration with the Care Quality Commission. A service that does not have a registered manager in place cannot receive a higher rating the 'requires improvement' in the well-led domain.

Care staff we spoke with had differing views about the quality of support they received from the interim manager. Some staff told us they found the interim manager approachable and would have no hesitation in going to them if they had any concerns or worries. They also felt supported by the interim manager and stated that they would raise any issues they thought were of concern. However, other staff told us they found the interim manager intimidating, unapproachable and not open to ideas.

The interim manager is expected to undertake audits set by the registered provider and improve services accordingly. We found that some audits had taken place and these included the environment, infection control, medicines and training. However, we found that audits of people's care flies had not been undertaken for a number of months and the gaps in people's care, identified as part of this inspection, had not been highlighted or addressed. The audits of medicines had not identified the issues found as part of this inspection. The lack of staffing and how this impacted on people's quality of care had not been identified as part of any audits. The lack of response to people's concerns had not been identified or acknowledged as part of any audits. We also found that issues identified at the last inspection had not been addressed, for example lack of meaningful activities for people living with dementia and the use of MCA and DoLS. The registered provider did not have systems in place which ensured people lived in a service which was safe, effective, caring, responsive and well-led. This is a breach of Regulation 17 Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

As a company, BUPA undertake a random selection of people to survey annually. These results are then collated and sent to the service. We saw this had been completed for 2015 and the results showed areas where people were not satisfied with the care or the service provided. The interim manager is then set an action plan to address concerns raised via the survey. This is checked and monitored by other senior managers in the organisation. Performance of the service is measured against other services within the company and there is an expectation the service achieves the standards set.

Daily meetings were held with each unit manager to discuss any issues and staffing levels, for example where the shortfalls were and which shifts needed covering. However, this was not always effective as we found shortfalls in staffing continued. We found staff meetings had been held on regular basis. Each team of staff had

Requires improvement

Is the service well-led?

attended different meetings, for example there had been care staff meetings, senior care staff meetings, nurses meetings and ancillary staff meetings. All the meetings had been minuted.

We found equipment used had been serviced at intervals recommended by the manufacturer and any repairs had been carried out as needed. Fire drills had been completed regularly and equipment tested as required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 9 HSCA (RA) Regulations 2014 Person-centred care **People did not receive care which was person-centred, effectively met their needs or was of their choosing.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not treated with dignity and their privacy was not respected.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People did not receive their medicines as prescribed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Complaints were not recorded or investigated.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider did not have systems in place which ensured people lived in a service which was safe, effective, caring, responsive and well-led.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Staff had not adhered to legislation which was in place to protect people when they lacked the capacity to make their own decisions.**

The enforcement action we took:
We have issued a Warning Notice for Regulation 11, Need for consent, to the registered provider. They have to be compliant with this Regulation by 29 January 2016.

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 **Staff were not provided in enough numbers to ensure people were safe and their care needs were met.**

The enforcement action we took:
We have issued a Warning Notice for Regulation 18, Staffing, to the registered provider. They have to be compliant with this Regulation by 1 February 2016.