Four Seasons Health Care (England) Limited

Preston Glades Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Preston Glades is a purpose built home, registered to provide accommodation for up to 65 people who require nursing or personal care. The home is arranged in two units. The first floor unit provides services for people who live with dementia.

All accommodation is provided on a single room basis, with the majority of rooms having en-suite facilities. There are a variety of communal areas within the home where people can spend their time, including a room for people who smoke.

At the time of the inspection there were 52 people who used the service.

At the time of the inspection there was a registered manager in post. However, they were not available during the inspection. Shortly, following the inspection we were informed that the registered manager would not be returning to their post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection of this service took place on 5 February 2015. The service was awarded a rating of 'Requires Improvement.' The service was found to be in breach of the regulation relating to record keeping. We were provided with an action plan following the inspection carried out in February 2015.

This inspection took place on 28 April 2016 and was unannounced. We found that standards at the service had not improved and we identified a number of concerns and new breaches of regulations.

Risks to the health, safety and well-being of people who used the service were not consistently well managed. Sometimes risks were not identified. In other examples we found that measures put in place following risk assessment, to help promote people's safety were not followed.

We identified concerns about the way people's medicines were managed. People's medicines were not consistently managed in a safe way, which meant they were exposed to unnecessary risks to their health and wellbeing.

We found the provider did not have effective arrangements in place to ensure that adequate numbers of suitably qualified staff were effectively deployed at all times. This meant people were at risk of not receiving the care they needed in a timely manner.

The rights of people who used the service were not always protected because the service did not consistently work in accordance with the Mental Capacity Act 2005. We found a number of examples where the service had failed to gain legal consent for the provision of various aspects of care.

We found evidence that staff at the service did not always support people in a manner that promoted their privacy, dignity and autonomy. Examples were seen of people being left in undignified situations and their privacy being compromised.

We found that in some cases there had been a failure to adequately assess and plan for people's needs. We also found that at times the service failed to recognise and respond to people's changing needs.

The arrangements for monitoring the quality and safety of the service were found to be inadequate. We identified a number of concerns and breaches of regulations which has not been identified or acted upon by the registered manager.

PEEPs (Personalised Emergency Evacuation Plans) were in place, but required improvement to ensure they were more personalised. We made a recommendation about this.

More robust auditing of medicines management and consideration of the NICE guidance, 'Managing Medicines in Care Home' was recommended to help ensure improvements were made and sustained.

There were clear recruitment procedures in place which were designed to help ensure only people of suitable character were employed. However, these were not always consistently followed. We made a recommendation about this.

We found some examples of effective nutritional care which included the prompt involvement of external professionals when risks to people's nutritional health was identified. However, this was not always the case and we also found some examples where people had experienced weight loss over several months before the appropriate referrals were made. We made a recommendation about this.

There was a training programme in place, which helped to ensure that staff had the appropriate skills to carry out their roles. However, a number of staff we spoke with felt they would benefit from the opportunity to take part in some classroom based learning as well as 'e - learning.' We made a recommendation about this.

We received some poor feedback about activities provided at the service. Some people felt that the provision of activities was of poor quality. We also noted that some people's preferences in relation to activities were not recorded in their care plans. We made a recommendation about this.

We found evidence that complaints were not always properly recorded and that the complaints procedure was out of date. We made a recommendation about this.

The service had safeguarding procedures in place which provided staff with information and guidance about how to recognise and report any concerns about the safety or wellbeing of a person who used the service. Staff demonstrated a good understanding of the procedures and their responsibility to report any concerns immediately.

We identified some positive examples of joint working by staff at the home with community professionals, for example, community health professionals. We saw evidence of some good outcomes for people which had been achieved through this positive joint working.

A team of senior managers from the organisation had been deployed at the home to support improvements. At the time of the inspection they were able to provide evidence that they had identified a number of areas

for improvement and were in the process of implementing action plans to address them. We received positive feedback from community professionals regarding the way the team had liaised with them. We noted that they had worked closely with the local authority safeguarding team and commissioners to ensure all such concerns were being investigated.

We found a number of breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 relating to safe care and treatment, staffing, consent, dignity and respect, person centred care and good governance. You can see what action we have told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to the health, safety and wellbeing of people who used the service were not always well managed.

People's medicines were not always managed effectively. This meant people were at risk of not receiving their medicines when they needed them.

There were not always adequate numbers of suitably qualified staff deployed to meet people's needs. There were recruitment procedures in place. However, these were not always followed in a consistent manner.

Staff were aware of their responsibility to protect people from abuse and knew how to raise any safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not always protected because the service did not always work in accordance with the Mental Capacity Act, 2005.

People did not always receive their care from staff who had the skills to support them.

Some examples of effective nutritional support were seen. However, we also found examples where people had experienced weight loss over periods of several months before dietician referrals were made.

Is the service caring?

Inadequate

The service was not caring.

People were not always supported in a manner that promoted their privacy and dignity.

The practices at the home did not always support people's opportunities to exercise autonomy and express their choices.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were not always fully considered when planning their care.

People's care plans were not always regularly reviewed and there were some gaps in the information contained within them.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Processes for monitoring safety and quality across the service were not always used effectively.

Opportunities for improvement were sometimes missed because adverse incidents and complaints were not always managed effectively.

Preston Glades 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 review the rating for the service under the Care Act 2014.

The inspection took place on the 28 April 2016 and was unannounced.

The inspection team consisted of three adult social care inspectors, a specialist advisor in the nursing care of older people and a pharmacy specialist. In addition an expert-by-experience joined the team. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert had experience of caring for someone who lived with dementia.

Prior to our visit, we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents. We also looked at information we had received from other sources, such as the local authority and people who used the service.

We spoke with fifteen people who used the service or their relatives during our inspection. We also had discussions with the area manager, patient experience quality manager and a floating manager who was covering the home at the time of the inspection. We spoke with the deputy manager, first floor unit manager, two nurses, an agency nurse, senior health care assistant and four carers.

We spoke with five community professionals and contacted the local authority commissioning team. Their feedback is included throughout this report.

We closely examined the care records of nine people who used the service. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs and manage any risks to people's health and wellbeing.

We reviewed a variety of records, including some policies and procedures, safety and quality audits, five staff

personnel and training files, records of accidents, complaints records, various service certificates and medication administration records.

Requires Improvement

Is the service safe?

Our findings

We found a range of risk assessments were present in all the care files we viewed. These addressed areas such as falls, moving and handling, nutrition and the risk of choking. Where risk had been identified, there was guidance in place for staff about how to provide safe care and support.

However, we spoke with two relatives who had some concerns about how risks to their loved ones' safety and wellbeing had been managed. One of these people had recently experienced a fall in the middle of the night. Their relative felt that there should have been clearer guidance for staff about how to protect them from falling at nights. On viewing this person's care plan we agreed that guidance specifically in relation to night time support, should have been clearer.

The other relative shared with us some concerns that risks associated with their loved one's dementia were not well managed. On viewing this person's plan we found that there appeared to be a lack of understanding on the part of staff about this person's needs. There had been some attempts on the part of the home to involve external professionals in planning the person's care, but we found that advice from external professionals was not always followed through by staff. This resulted in the safety of the person and those around them being compromised at times.

The local authority safeguarding team were aware of these concerns and were working with the home to support improvement at the time of the inspection.

There were a variety of risk assessments in place relating to general safety within the home. However, we found evidence that the safety measures detailed within them were not always adhered to. For example, COSHH (Control of Substances Hazardous to Health) risk assessments stated all cleaning fluids and chemicals must be locked away at all times. However, we found several doors of rooms containing such items, unlocked throughout the day.

During a tour of the home we observed a number of identifiable hazards including an unlocked empty room with some disused furniture in place. Extensive building work was ongoing in the home, but there was no daily risk assessment to assess the work of the day and what new hazards this may present to people who used the service.

The failure to assess and manage risks to people's health and wellbeing was in breach of regulation 12(1)(2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We assessed how people's medicines were being managed during this inspection. We viewed people's medicines records and stocks of medicines in the home. We observed medicines being administered and spoke with staff responsible for this task.

We also spoke with people who used the service, or their relatives about how their medicines were managed. Most people felt they, or their loved ones, received their correct medicines at the correct times.

However, one family member we spoke with explained their relative did not always have a prescribed cream applied and told us at times, the family had applied it themselves because staff had not done so. Another relative told us that their loved one had been given the wrong medication on several occasions and that their own medicines had been allowed to run out, on more than one occasion.

We found that medicines were being stored securely on both floors of the home. However we found four medicines that had been stopped were still stored in the trolley: one had been stopped on the day of our inspection, two had been stopped sometime within the previous month and there was one bottle of eye drops, which was out of date by several months. Discontinued medicines should be disposed of safely to reduce the risk of them being given when they are no longer prescribed.

We noted that creams belonging to people who lived with dementia were stored under their sinks in their bedrooms. We discussed this with the unit manager who told us he wasn't aware of any risk assessments being carried out to ensure this storage was safe for individuals. He agreed to review this immediately.

We checked medication administration records (MARs) for 16 people to see what medicines had been given, and carried out audit checks on 24 medicines. We found six MAR charts, which had been handwritten instead of printed by the pharmacy and found a second member of staff had checked the records. This reduced the risk of the information being written incorrectly. However, we found that these handwritten records did not always clearly contain the quantities of medicines received or stock carried forward, so it was not always possible to check medicines had been given in accordance with the records.

Some medicines that needed to be given before food were stored and recorded separately to be given before breakfast, so it was clear people were being given these at the correct times. Some people had individualised care plans about 'when required' medicines, which clearly described the treatment and the needs of the person. However these protocols were not consistent; one record was missing and another record was still present even though the 'when required' medication had been stopped.

When viewing people's MARs we found some people were frequently refusing to take their medicines or were sometimes sleeping in the morning and as such, not given their morning medication. One person was prescribed a medicine to be taken at 7am but had refused to take it on eight occasions and had also missed four doses due to being asleep. Staff had not sought any advice regarding this until a few weeks later, when the dose was altered to be given at 9am.

Another person was written up to be given their medication covertly; this means if a person refuses to take their medication, the medicine can be hidden in food or drink to ensure the person takes it. The nurse had completed all relevant documentation around assessment and best interest discussions and notes in the person's care plan stated to continue to give the medicines covertly to ensure compliance. However, the person had refused some or all their medicines fifteen times over the past two months and had not been given their medicines covertly as their care plan advised. We looked at this person's daily notes and found reference to refusing medication, but no concerns over dietary intake, so it was unclear why the person was not given the medicines covertly. Another person had also refused medication on five occasions over the past two months, but had a covert plan completed by a mental health nurse, which had been signed by the resident and care home nurse. The person's care plan stated they had variable compliance with their medication, but did not usually need their medication to be given covertly. Appropriate assessment and best interest paperwork was not in place.

Another person who used the service was prescribed a pain relief patch. Records showed that the person had ran out of stock of their patches and as a result, had not had a patch applied for fifteen days. We

discussed this with the deputy manager who told us there had been a problem registering the person at a local GP practice. However, there were no notes or records to confirm this had been followed up. We spoke with the person who told us she was not aware she had not been given the patch, but had not been in pain and wondered whether she still needed the medication. Staff had not sought any advice and had not tried to obtain emergency medication or temporary GP registration for the person. We reported this situation to the local authority safeguarding team so that an investigation would be carried out.

We found further discrepancies relating to how staff managed medication changes. One person's medication dose was altered from a 'when required' dose to a regular, twice a day dose. Administration records were not signed accurately; there were gaps in signatures and it was unclear if the person had received a regular dose as the stock had not been accounted for, so it was not possible to do any audit checks. When further stock had been booked in at the start of the next cycle, the medicine dose was incorrect on the MAR chart and so the person was then given the medicine on a 'when required' dose and did not receive a regular dose for four days.

These findings demonstrated that staff were not always dealing with concerns for individual people in a timely manner and were not following correct procedures for the refusal of medicines and covert administration. In addition, the home did not have robust processes in place for booking medicines into the home or dealing with changes to people's medication. As a result, people did not always receive their medicines as prescribed.

This was a breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We discussed our findings with the members of the management team within the home, as well as two senior regional managers from the organisation. The regional manager was able to provide evidence that concerns in relation to medicines management had been identified prior to our inspection and an action plan had been implemented to drive improvements.

The manager of the unit for people who lived with dementia advised us that he had started daily audit checks to help identify any problems quickly. In addition he had appointed three medicines champions to help him review the unit processes to ensure staff followed best practice. We also noted that meetings had taken place with the supplying pharmacy and local GP surgery to discuss the ordering of prescriptions and communication. He had also introduced stock checks on boxed medication to help record the audit trail for these medicines. However we found the audit checks to be infrequent and these checks had not identified some of the issues found at the inspection. The regional manager told us there were also other weekly and monthly audits, but that the company had recognised that these were not thorough and as a result company audit procedures were being reviewed. It is recommended that a more robust framework of audit checks is in place, and focused on staff following policy and procedures. It is also recommended that all procedures are reviewed in accordance with the NICE best practice guidance 'Managing Medicines in Care Homes 2014.'

We spoke with people who used the service and their relatives about their views on staffing levels at the service. The feedback we received was mixed. Some people felt that staffing levels were generally adequate and told us they received assistance when they needed it. However, others raised concerns that at times, the home felt short staffed and several commented on what they felt had been a recent increase in the use of agency staff. One relative we spoke with raised concerns that staff did not sometimes appear to be well organised. They described a recent occasion when they attended the home and could see two people clearly in need of support but found that all staff members on the unit were in the office, eating.

A community professional who regularly attended the home told us that on several recent occasions, they had observed several staff members going on breaks at the same time, creating a shortage of staff 'on the floor.'

The service had a tool in place, which helped to determine necessary staffing numbers in accordance with the needs of people who used the service. However, rotas showed that the home had not always been staffed in accordance with the tool. One staff member commented, "There have been times when we have been really short. Usually due to people being off sick." Another told us, "Most of the time when I'm on it's been ok, but some staff have said it's been bad, sometimes I have been told there have been only three people on. We have been using agency sometimes, it can make things harder to be honest". A third staff member commented, "At the moment it is quite good. It has been bad though up to a few weeks ago, in some instances we were two or even three members of staff down. All the time I have been here we have never needed agency staff, until the last few months. "

Rotas viewed confirmed there had been a high use of agency staff at the home in recent months. We spoke with managers about this who acknowledged the increase and advised us a robust recruitment drive was ongoing in an attempt to recruit more permanent staff. Investigations were also taking place in an attempt to ascertain why there had been such a high turnover of staff recently, which had resulted in the increased requirement of agency staff.

We noted some concerns about how agency staff were sometimes deployed within the home. We tracked the care of one person whose placement at the home had recently broken down. This person had some very complex needs and had required one-to-one support throughout the day. Records showed that despite community professionals advising against it, agency staff had sometimes been deployed to support the person. This had resulted in at least one occasion, when the resident had not been safely supported, which had resulted in an adverse incident. It was not clear why arrangements had not been put in place for permanent care workers, who knew the person well to support them, whilst agency staff carried out less complex duties.

The above findings demonstrated a breach of Regulation18 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Each person who used the service had a personal emergency evacuation plan (PEEP) in place. The PEEPs we saw were located in people's individual care records and also in a separate file at a central location within the home, for easy access in the event of an emergency. However, we found PEEPs were not person centred. They were generic documents and contained basic information only. It is recommended that personalised information about people's needs is included in their PEEP, so that information is readily available to evacuate people in the most effective and safe way, in the event of an emergency.

We noted a grab bag was available for use in emergency situations, such as evacuation of the premises. A check list was visible, which showed that the contents were regularly checked, to ensure all were present and correct.

The service had a policy and related procedures in place, which provided staff with guidance about their responsibility to protect people who used the service from abuse and improper treatment. The guidance, referred to as safeguarding procedures included information for staff about how to report any concerns and contact details of relevant agencies, such as the local authority safeguarding team.

Records showed that all staff were required to undertake safeguarding training as part of their induction, at

the start of their employment. All staff we spoke with were fully aware of safeguarding procedures and how to escalate any concerns regarding the safety and wellbeing of someone who used the service.

Our records showed that the registered manager reported any safeguarding concerns to the appropriate agencies in a timely manner and cooperated in any safeguarding investigations carried out.

We viewed a selection of staff personnel files. We found that although there were clear recruitment procedures in place, these were sometimes applied inconsistently. This meant not all the necessary background checks had been carried out for each new staff member.

Generally, a range of background checks were carried out for every new staff member, which included proof of identification, references relating to previous employment and a DBS (Disclosure and Barring Service) check, which would show if the individual had any criminal convictions or had ever been barred from working with vulnerable people. However, we found in some examples, that pieces of information relating to background checks were missing. In one person's file there was no evidence of any references being obtained. In another, we found that the registered manager had failed to obtain photographic identification for the staff member.

Failure to follow the service's recruitment procedures thoroughly meant that people were not protected against the risks of receiving care from unsuitable staff members as well as they could have been. It is recommended that an audit of all staff personnel files be carried out to ensure any missing information is obtained and that going forward, the service's recruitment procedures are closely followed at all times.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Evidence was available to demonstrate that staff had submitted DoLS applications for a number of people who used the service, by way of central records held. The registered manager had a matrix in place, which enabled her to track the progression of each application. However, this information was not always clear in relation to individual people, in their care plans.

In some examples, we found that DoLS applications had been submitted, but there was no evidence that mental capacity assessments had been carried out to assess whether the person had capacity to consent to their care or accommodation.

Written consent to various aspects of care and treatment was observed on some people's files. However, in others, consent forms had not been completed. They were present in people's care files but left blank. We also found some examples where consent had been provided by people's family members, but there was no confirmation that the people who had provided consent had legal authority to do so.

Not all restrictive practices were adequately recorded. One person whose care we tracked had a DoLS application in place, which was being assessed by the relevant authority. However, the application did not include the fact that access to her clothing was sometimes restricted by staff.

These finding demonstrated a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We were advised that all new staff were required to undertake an induction programme at the start of their employment. The induction programme covered areas such as health and safety and safeguarding and had been reviewed in line with the nationally recognised care certificate. However, induction records we viewed were inconsistent. Some staff personnel files did not contain any induction records and there was no way of determining that induction training had been provided.

Care staff were encouraged to complete nationally recognised qualifications in care and we saw that all care workers either held these qualifications or had started the relevant courses.

There was a further mandatory training programme in place, which included a number of areas such as safeguarding, mental capacity and annual refreshers in health and safety modules, such as moving and handling. Staff we spoke with described training they had undertaken, which included NVQs at level 2 and 3, dementia training and end of life care.

In discussion, several staff members commented that the majority of training provided was by way of 'e learning.' This was not popular amongst the staff we spoke with. Their comments included, "I don't get enough to be honest." "The last face-to-face training I got was a couple of years ago." "It is mostly e-learning. I don't like it. Face-to-face training hasn't happened for a while now." "It is all e-learning, it's boring. I don't get much from it."

People felt strongly that more face- to-face learning would be beneficial. We shared this view with senior managers from the organisation who demonstrated they were aware improvements to the training programme were required. They were able to demonstrate they were taking steps to improve the training programme, including the provision of more face-to face training.

At the time of the inspection, two senior care workers were due to commence a 12 week training programme known as the CHAP (Care Home Assistant Practitioner) training. This was a 12 week coursed designed to provide them with skills to carry out enhanced care interventions and medicines administration.

We saw the course was taught by a Nurse Regional Trainer and supported by the Company for identified Senior Carers to access. We were advised that staff undertaking the course would be supernumerary to the staff ratio. It was stated that staff completing the CHAP course would not be expected to carry out new tasks until competency assessments had been completed according to company protocols.

We were advised that the course completion would take into account what training had already been done by the staff member and therefore potentially reduce the time of the course. However, it was not clear how this course could be adapted according to previous competencies and yet be accredited by the company as a Standard Course for staff to apply for and complete. In addition, it was unclear how staff that had completed the course were monitored or supported in competency assessment updates.

A community professional we spoke with as part of the inspection shared some concerns about the skills of staff to support people who lived with dementia. They felt that staff did not have the appropriate knowledge and understanding to support people who had more complex behavioural; needs. We identified similar concerns when pathway tracking the care of a person who had such needs. Some of the language used by several staff members in the person's care records, clearly showed that they did not understand the person's needs or how to support them properly.

Some people we spoke with reported a recent increase in the numbers of agency staff employed at the home. People's comments included, "The staff are mainly agency staff and you would rarely see the same staff member twice." "Recently there have been a few issues with people ringing in sick. They have been covered, mainly with agency and it is usually upstairs [unit for people who live with dementia]."

In viewing records of adverse incidents and their analysis, we saw that the registered manager had on several occasions, recorded the use of agency staff as being a contributing factor. For example, in a number of medications errors and the breakdown of one-to-one support for a person who had complex needs.

The above findings demonstrated further evidence of a breach of Regulation18 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There were arrangements in place to provide staff with regular one-to-one supervision and annual appraisal. However, records showed that this process had fallen behind and some staff had not received a supervision or appraisal for several months. One staff member told us, "I'm probably due one soon. I think I had one a few months ago and we have them every six months or so. We don't have annual appraisals."

Records showed that a range of community professionals, such as GPs, speech and language therapists, opticians, dieticians and mental health teams were involved in the care and treatment of those who lived at Preston Glades. Evidence was available to demonstrate that hospital advice was sought in the event of a medical emergency or should there be serious concerns about someone's health.

We found some positive examples of good joint working with community professionals, which had resulted in people receiving effective care and support. For example, the care plan of one person with a pressure wound provided documentary evidence of a co-ordinated approach by staff at the home, the GP, tissue viability nurse and dietitian, to provide care and treatment. Records showed this co-ordinated approach had resulted in improvement of the person's health and well-being.

We viewed the care plan of another person and found clear, concise instructions had been provided by a tissue viability nurse and dietician. We observed staff following the guidelines throughout the inspection. We also observed the use of appropriate equipment such as pressure relieving equipment, throughout the day.

However, when viewing some people's care plans and records we found some information relating to their health care needs was unclear, and is some cases, difficult to follow. We viewed the care records belonging to one person who had a PEG (Percutaneous Endoscopic Gastrostomy) in place. The records relating to this were inconsistent and it was extremely difficult to assess the correct nutrition regime for the person. It took three inspectors, all with nursing or pharmacy expertise, a significant amount of time to clarify the correct regime. As the home had agency nurses on duty quite frequently, this was a concern.

Some care plans we examined had not been reviewed in relation to various aspects of health care, for example pressure care, for several months. Some of the records had not been updated for several months, despite changes in people's needs.

We spoke with a visiting health professional during the inspection. They had provided advice to staff regarding wound care for a particular resident, which they were satisfied had been carried out correctly. However, they advised us that staff at the home had failed to obtain further wound dressings for the person despite previous instructions to do so. It was understood that dressings had been brought in by the family. A family member we spoke with also raised concerns about the failure of the service to ensure appropriate dressings were in place for their loved one.

Access to healthcare professionals for people who used the service was apparent and confirmed during most discussions with people, their families, staff and visiting health professionals. Referrals were usually reported as being timely and appropriate to ensure effective care and support was provided. We were advised that the home had access to a dedicated community nursing service throughout the day and night.

We found some examples of effective nutritional support. For example, the care plan of one person demonstrated that care staff had acted promptly when the person had experienced weight loss and sought advice from community professionals including speech and language therapists and dieticians. However,

this good practice was not consistent throughout the service.

One family member we spoke with shared some concerns with us about the nutritional support their relative had received during their stay at the home. They told us that their relative had lost a significant amount of weight. We confirmed this to be the case when we viewed the person's care plan. We saw that despite the significant loss of weight, which had been noted by staff, a referral to a dietician had not been made for several months. This was not consistent with the person's nutritional risk assessment and care plan.

Another relative described how their loved one had lost approximately 21 pounds during a four month stay at the home. They told us, "If [name removed] refused a meal or was asleep, the meal was not re-offered later and he would miss meals."

During the inspection we observed the relative of a person who used the service speak to staff because their relative had not been provided with a meal. This occurred at approximately one hour after the meal time service. The meal was duly provided. However, it was a concern that had the relative not been there, this person would have missed their meal, as they were not able to alert staff to the fact they had not eaten.

The regional manager was able to provide us with evidence that the area of nutritional support had been identified by them as requiring improvement. As such, a number of measures had been taken, which included increased audits of people's weight records with the aim of ensuring appropriate referrals were made in a timely manner to the relevant professionals. In addition, procedures for recording people's intake of food and fluids were under review with the aim of making improvements.

We spoke with people about the standard of food provided at the service. People were generally satisfied, but we did receive some mixed comments. One person commented, "I like the food and there is plenty of choice." Another told us, "I've no complaints about the food at all." However, other comments about the food included, 'adequate at best' and 'not good.'

One of the inspectors joined people who used the service for lunch. They noted that people were provided with choices throughout the meal service and that there were adequate numbers of staff present to assist all those who required it during the meal. We saw that people were able to choose whether to eat their meals in the dining room or in their own private rooms. Drinks and snacks were seen to be available throughout the day.

We carried out a tour of the home during the inspection. We found the majority of areas to be clean, warm and comfortable. We saw that people's bedrooms were homely and personalised with their own possessions.

Some improvements had been made to the environment and this process was ongoing at the time of the inspection. Such improvements including the re-structure of the unit for people who lived with dementia and the refurbishment of several communal spaces and bathrooms. However, we were made aware during the inspection that some assisted bathrooms had been out if use for several weeks. In one area of the home people did not have access to an assisted bath and we were told that people had only been offered a shower during this time. One staff member told us, "It has been broken for a number of weeks now. We are using the shower room but it's not ideal." We spoke with senior managers about this situation and requested it be rectified as a matter of urgency. It is also recommended that procedures for obtaining agreement from the provider and actioning urgent issues such as this be reviewed so people are provided with adequate facilities at all times.

Inadequate

Is the service caring?

Our findings

People we spoke with told us they felt cared for and that their needs were met. Their comments included, "I'm comfortable", "I get the things I need" and "It's adequate." One person spoke very highly about the care they received from a specific carer. A visitor commented, "The staff are very approachable and you can talk to them."

However, other comments were, "There is no love here, they have forgotten how to love here." "Some staff are ok and some are not, they just walk away from you." "There is plenty of staff but they stand talking. The staff are just doing a job. They just ignore you and can't even say goodnight when they are leaving."

We observed staff as they went about their duties and provided care and support. We saw that most people were treated with kindness and compassion and that staff were respectful towards them. However, more notably on the ground floor unit, we observed that staff although demonstrating a caring approach, had less time to spend with people and only undertook tasks as were needed and were less responsive.

On the first floor unit we observed some good examples where staff members anticipated people's needs well and took action to make them comfortable. For example, one care worker was seen to ask a person if they were comfy and whether they were cold. The care worker quickly provided a blanket and the person responded by saying, "That's better!"

We also noted there appeared to be ample staff on duty on the first floor unit to give more one-to-one care to residents. This was especially observed in the afternoon and at a tea time meal.

However, we did observe an example of very poor communication from a staff member on the first floor. The care worker was seen assisting a person who was very clearly upset and distressed and was obviously trying to communicate something. The care worker walked away from the person who started to get more distressed and cry out. It was a member of the catering team who then attended the person and got to the bottom of why she was upset and duly rectified the situation. It was of concern that the care worker had not done so.

We found on the ground floor unit that staff did not always have a good knowledge of the people they were supporting. Two permanent care staff members did not know the name of a person who had been admitted to the home several days earlier.

People's plans of care incorporated the importance of respecting people's privacy and dignity, particularly during the provision of personal care. However, we observed on several occasions people with minimal clothing on their lower bodies, in their bedrooms with their doors open.

We noted that some people were not supported to be presented in a manner that promoted their dignity. For example, two people we spoke with had food stains on their clothes.

Most people's care plans contained a good amount of information about their social histories. This included information, such as important relationships, significant life events and previous employment and hobbies. However, in two examples, both of the people who had lived at the home for several months, we found that none of this information had been completed. This meant the opportunity to obtain important information, which would help care workers get to know people and understand how they wanted to be supported had been missed.

We noted on the first floor unit for people who lived with dementia, there were pictorial menus designed to provide information to people about the meals of the day, who may not be able to access written information. However, it was disappointing to find that the pictures being displayed were not accurate and were of different meals than the ones being served. This did not assist people in making choices or exercising control.

A number of people we spoke with raised concerns about the laundry service at the home. One person described it as 'disgraceful.' People described their loved ones' clothes and belongings going missing and often finding them dressed in other people's clothes. In addition, we heard from several people whose loved ones' reading glasses or hearing aids had gone missing. This did not promote people's dignity, autonomy or individuality.

We visited one person in their bedroom. There was a clear notice attached to the side of their wardrobe, which stated, 'I would like my door to be closed when I am in my room.' However, we found their bedroom door was being kept fully open with an electronic door guard.

The failure to ensure that people received care in a manner that promoted their dignity and autonomy was a breach of regulation 10 (1)(2)(a)&(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Training records showed that the majority of staff had completed training in providing care to people at the end of their life. In one care plan we viewed we saw that an advanced plan of care had been generated. This had been developed with a close relative, who had legal authorisation to make decisions about the person's care. The care plan included a good level of information about how the person wished to be cared for, during their final days.

However, one visitor we spoke with, whose loved one was receiving end of life care, felt that communication about their loved one's care could be better. They told us they found it difficult at times to find a staff member that knew their relative well enough to speak with. They also advised us that they had waited for a re-assessment of their relative's care plan to take place for several weeks.

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback from people we spoke with about their experiences of care and support. The majority of people we spoke with were generally satisfied with the service but felt there were a number of improvements that could be made. However, two family members we consulted raised concerns about how the service had responded to their loved one's needs. In both cases the people we spoke with felt that staff had failed to review their loved one's care, in accordance with changes in the care and support they required.

There was a process in place to carry out assessments of people's needs prior to offering them a place at the service. This was designed to ensure that the person's needs and whether they could be met, would be properly considered, before agreeing to admit them. However, we found that this process was not always carried out effectively.

We tracked the care of one person who had some complex needs and at times, presented behaviours which could be a risk to themselves and others around them. We saw that the person who carried out the pre-admission assessment for this person was made aware of their complex needs during the assessment process, but made the decision to admit them, without first considering whether staff had the skills to meet their needs.

The person's placement did not go well and there had been a number of concerns about their care. It was apparent that some staff did not have the skills to meet this person's needs and some of the written records they made, demonstrated very little understanding and insight into them. We heard from a family member of this person, who told us, 'They knew when they agreed to take [name removed] into their home that he had behavioural problems from the Alzheimer's and they assured us they had the experience to deal with this. But quite clearly they didn't.'

The home had attempted to involve other professionals from the community to assist in meeting the person's needs. However, we found evidence that their advice had not been consistently followed.

Other files viewed showed that people's needs had been assessed before they were admitted to the home. Plans of care had been generated from the information gathered during the pre-admission assessment and these had been developed with the involvement of those who lived at the home or their relative.

We viewed a selection of people's care plans. We found that some were difficult to track through. Often, important information was included in review sections of the care plans, but not in the actual care plans themselves. As staff would not read the review sections each time they referred to a care plan, this was not an effective way of recording changes.

Some people's care plans contained confusing and conflicting information. For example, different information regarding the person's moving and handling needs or nutritional needs. This meant that some people's care plans were confusing and increased the risk of people receiving unsafe or ineffective care.

There was evidence seen of some care plans being up-to-date and relevant. However, others had gaps in documentation or had not been reviewed for several months, despite them having changing or complex needs.

Some staff we spoke with felt that communication about changes in people's needs required improvement. One care worker told us, "If you have been off it's only (the handover) for that night. I was off for a week and one person had come back from hospital and their needs had changed. I wasn't told."

The above findings demonstrated a breach of Regulation 9 (1)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found some good examples of person centred information within people's care plans. These included, 'My Preferences' and 'This is me' sections, which contained information about people's likes, dislikes and preferred daily routines. However, these were not completed in all cases.
We spoke with people about their views on the activities provided at the home. The feedback we received was largely negative. People's comments included, "There is no stimulation or activities for the residents to access and no staff employed to work with the residents and entertain them." "I hate just sitting around."

We asked people about the activities that were advertised in the home and no-one we spoke with felt the advertisement gave a true reflection. One person said, "It just doesn't happen." Another person told us they had constantly requested their choice of newspaper be obtained on a daily basis, which they had offered to pay for themselves but this had not been provided.

The residents on the ground floor appeared to either sit in the main reception lounge area or opposite the lift and did not appear to use a second lounge area at all. No activities appeared to be undertaken on the day of the inspection and even though some residents were dressed, they remained asleep for long periods of time.

We spoke with a staff member who told the activities co-ordinator at the home had been off for some weeks and as a result, activities had not been provided, as care staff did not have the time to provide them.

We found some examples where people's needs and preferences in relation to activities had not been completed in their care plans, despite there being a specific section for this information. This was of particular concern in relation to one person, as community mental health professionals had advised a comprehensive activities care plan to be implemented to help support them.

None of the people we spoke with recalled being invited to provide feedback to the service in a formal way, such as through satisfaction surveys or residents meetings. However, evidence was available to show that a range of surveys were conducted every three months. These included questionnaires for those who lived at the home, their relatives, visiting professionals and staff. The overall results were produced in a pie chart for easy reference and the overall quarterly trend was displayed in a graph format.

A written complaints policy was in place at the home and this was included in the service user's welcome pack, but was not on visible display within the home. However, this policy had not been reviewed or updated since 2006 and therefore the information was not current. The policy stated that the complainant would receive an initial response within 48 hours, but no other timeframes were included, such as the period of time for the investigation or the concluding response. It is recommended the policy be reviewed and updated to contain current information.

A system was in place for recording any complaints received by the home. The last complaint documented was recorded as being received in October 2015. However, we were aware through our discussions with people, that there had been at least two additional complaints made since that time. A family member we spoke with told us they had raised a number of concerns about their loved one's care. They were yet to hear the outcome.

As complaints were not always carefully recorded this meant it was not possible for the registered manager to have an overview of concerns raised and whether there were any themes or trends to be learned from. It is recommended that a thorough record of all complaints is maintained and updated in a timely manner, not only to enable the registered manager and provider to have an overview of concerns raised but also to demonstrate that complaints have been properly investigated and responded to.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection the registered manager was on leave from the service. We were informed shortly after the inspection that the registered manager would not be returning to the post. A team of senior managers from the organisation has been appointed to work at the home on a full time basis, as well as a floating manager, who had experience of services that were in need of improvement.

We received variable feedback about people's views on recent management of the home. Several community professionals who had been involved in recent safeguarding investigations reported some difficulties in obtaining information in a timely manner. However, we were told this situation had improved significantly with the arrival of the new management team.

Some staff members we spoke with also reported some concerns. One person told us they had found it hard in the past, to take issues to some members of the management team as they had not found them to be approachable. Another expressed concerns that confidentiality was poor and that if you were absent due to sickness, when you came back, people knew why you had been off, even if the absence was of a personal nature.

Other staff comments included, "I think staff morale is fine." "I enjoy it here sometimes." "Staff morale is OK." "I think things could be a bit more organised, communication isn't very good." "I don't really speak to the management to be honest. I never get feedback on how well I'm doing my job." However, several people we spoke with felt that the implementation of the new management team was a positive development and told us they felt more supported.

We spoke with a newly appointed unit leader who recognised the issues we had identified. They told us the new management team had been very supportive and listened to what he thought was needed. He was also impressed by the way they had kept him informed of what developments were taking place. He said, "They are always asking me my opinion. I think morale is quite low at the moment. We are all trying to change that by talking to staff."

Records showed a range of internal meetings were held regularly. These included different groups of people, such as those who lived at the home, clinical governance managers, health and safety representatives, heads of departments and the staff team. This enabled people to voice their opinions within an open forum and to discuss any topics of interest.

However, on a day-to-day basis we saw that the cascade of information about people who used the service was not consistently well-led. For example, the daily handover to all staff members on the ground floor had not appeared to be effective, due to missing prescriptions for dressings and two staff members not knowing a person's name or care needs.

There were systems in place designed to enable the registered manager to monitor quality and safety across the service but we found these had not been used effectively at times. We identified a number of areas that

required improvement and several breaches of the health and social care act during the inspection. Whilst it is acknowledged that the new management team had also identified a number of these areas and had started to take action to address them, they had not been identified by the registered manager.

We saw there were gaps in the completion of manager audits, which had occurred over several months. Monthly regional manager audits had been completed according to the schedule, but requests made within them had not been actioned by the registered manager.

We found evidence that indicated a lack of communication between the registered manager and the organisation. The regional manager was unaware of several recent safeguarding concerns and recommendations made by external professionals as a result.

There was a system in place for overseeing adverse incidents, such as complaints or safeguarding concerns. However, the registered manager had failed to report a number of issues through the system which meant they had not been properly analysed. This meant opportunities for improvement had been lost.

There was a 'lessons learned' element to this reporting tool, which we noted had not always been used effectively. For example, we saw one record which failed to acknowledge recommendations for improvement made by an external professional as part of the 'lessons learned' section.

The above findings demonstrated a breach of 17 (2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The new team of managers in place at the home were working closely with the local authority and other relevant professionals on an ongoing basis. A comprehensive action plan for improvement had been developed by the team and this was being updated on a weekly basis. Following our feedback from this inspection, the action plan was updated to ensure it covered all the areas identified.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 The registered person had failed to ensure that people's care was planned in a way that met their needs and reflected their choices and preferences. 9(1)(a)(b)

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 The registered person had failed to ensure that people were treated with dignity and respect and that their autonomy was supported. 10(1)(2)(a)(b)(c)

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 The registered person had failed to ensure that legal consent was obtained from or on behalf of people who used the service for their care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure that

Treatment of disease, disorder or injury	safe care was provided by assessing the risks relating to people's care and taking all practicable measures to mitigate such risks, including arrangements to ensure people providing care have the correct skills to do so. The registered person had failed to ensure that adequate arrangements were in place for the safe management of medicines. 12(1)(2)(a)(b)(c) & (g)

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 17. Good governance. The registered person had failed to implement systems to effectively monitor the safety and quality of the service. 17 (1) (2) (a) (b) (e) (f)

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 18. Staffing. The registered manager had failed to ensure that sufficient numbers of suitably skilled, qualified and competent staff were deployed to meet people's needs safely. 18(1)