HC-One Oval Limited

Avon Court Care Home

Inspection report

St Francis Avenue
Chippenham
Wiltshire
SN15 2SE

Tel: 01249848894

Date of inspection visit:
04 June 2018
05 June 2018

Date of publication:
05 October 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over two days. The inspection started 4 June 2018 and was unannounced. We returned on the 5 June 2018 to complete the inspection.

People living at Avon Court received accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Avon Court is registered for up to 60 people to live at the service. At the time of the inspection there were 45 people living at the home.

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

We previously inspected the service in February 2017 and found there to be one breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that care plans did not always reflect accurate details around how care staff could support people's care needs. We issued the provider with a requirement notice to ensure improvements were made. At this inspection we found that care plans continued to not always provide sufficient detail in explaining what support a person required. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we also found five additional breaches of the Regulations.

People and their relatives gave us mixed feedback about how caring the service was. Some people told us they felt the staff team were caring. While other relatives we spoke with were upset when speaking about the quality of care their family member received.

Some care plans were out of date. To find out a person's up to date needs we had to look at monthly reviews over a period of one year. We observed that people who required support to drink were not always supported in accordance with the guidance in their care plans. There was guidance in place where healthcare professionals had been consulted with, yet this was not always followed. Some people's drinks remained untouched throughout the day. Some relatives told us they had to visit daily to ensure that their family member had something to drink. Where people were prescribed thickener for drinks, used to reduce the risk of choking, this was not recorded or used consistently. This left people at risk.

There were gaps in people's care records. Repositioning records suggested that people went for long periods of time without being repositioned. Pressure ulceration develops when people are not supported to change their position regularly. We also found that the recording process for pressure ulcers was not following best practice. Wounds were photographed, but details of the wound were not recorded. For example, where the wound was on the person's body, the size of the wound, or whether the wound

improved had not been documented. After the inspection we received information that an additional two people had developed pressure ulceration. The fact that people had developed pressure ulceration supports our findings that this aspect of people's care is not well managed.

People's personal hygiene charts were not always completed. This included no recordings for one person's oral hygiene support during a period of one month. The administration records for topical medicines, such as creams and lotions, were not always completed.

Daily records were task focussed. We reviewed records that focussed on what was done to people, rather than the choices people were supported to make.

People, their relatives, and staff told us the service was short staffed. At times during the inspection we saw that staff were not always present and available to people when they were needed. At other times the staffing levels meant that people were still being supported with morning personal care at lunch time. This meant that people were kept waiting in the dining room for staff to be available to offer them support. The information and concerns that have been received following the inspection support our findings that there are not enough staff to meet people's needs.

We observed undignified interactions. These included staff moving people in their wheelchairs without communicating with them. We saw that one person was upset and asked staff if someone was free to spend time with them. It took over one hour for a staff member to see the person, and by that time they had fallen asleep.

People's privacy wasn't always respected. We saw staff frequently walking into people's bedrooms without knocking or introducing themselves.

Staff understood how the Mental Capacity Act 2005 (MCA) applied when people lacked capacity. Capacity assessments and best interest decisions were in place. We observed that staff were not always offering people choice or seeking their consent to give support.

Where people received their medicines covertly, the appropriate capacity assessments were in place. Relevant healthcare professionals were consulted around decisions made in people's best interests.

Despite our observations of poor interactions, we also saw short periods of kind and caring engagement between people and staff. People and their relatives praised the activities provision and we saw evidence that people received one to one time on average once a week.

The quality monitoring systems identified most of the concerns we found at this inspection. There were audits of the service being completed and the findings from the audits were added to an overall home improvement plan. Action was not taken in a timely manner by the provider to make positive changes in response to shortfalls identified by the registered manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were gaps in care records which meant the service could not demonstrate people had received the care they needed.

Staff were not deployed effectively to make sure people could have the help and support they needed at the time it was required.

People were at times supported in a way that conflicted with guidance from healthcare professionals.

Medicines rounds were interrupted which meant nurses were at risk of making errors.

Is the service effective?

Requires Improvement

The service was not always effective.

Whilst staff were aware of the principles of the Mental Capacity Act (2005) it was not demonstrated in their practice. Staff did not consistently involve people in day to day decisions.

People were positive about the food they received.

People could access their GP and other professionals where needed.

Staff had received training and supervision appropriate for their role.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity were not always promoted.

There were loud conversations between staff, where people were spoken about as tasks.

We received mixed feedback about whether the staff team were caring.

People could bring in their own small items of furniture where they wished.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always feel they could approach the registered manager to raise concerns.

People did not always receive care that was responsive to their needs. Care plans were not updated and did not contain enough detail.

Some staff told us they did not always have time to ensure people received adequate personal care.

People praised the activity provision.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service was transitioning to a new provider. This meant paperwork and systems were in the process of changing.

Audits were completed and the information formed part of the home improvement plan. Audits had not identified all of the issues we had found during our inspection.

Action was not taken in a timely manner by the provider to make positive changes in response to shortfalls identified by the registered manager.

Avon Court 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under The Care Act 2014.

Before the inspection we reviewed information from notifications received from the service regarding accidents and incidents. We also looked at information provided by the service in their Provider Information Return (PIR). The PIR tells us what the service feels is working well and any areas they have identified as requiring improvements.

This inspection took place on 4 and 5 June 2018 and was unannounced. The inspection was conducted by three inspectors 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.

During the inspection we spoke with 16 people who used the service and 15 relatives. We spoke with 12 members of staff, either by formal interview, or in informal conversation throughout the inspection. These included, care staff, activities staff, nurses, housekeepers, kitchen staff, the quality manager, deputy manager and registered manager. We spoke with three healthcare professionals visiting the service during the inspection.

To gather evidence relating to people's care. We reviewed care plans and daily records for fifteen people. In addition, we checked the archived records and medicine administration records for each person. In the afternoon of the first day of the inspection we observed the medicine round on each unit. We also spent time observing the way staff interacted with people who use the service observing the lunchtime service in the dining rooms and people's bedrooms.

We reviewed records relating to the management of the service. This included looking at audits, call bell response times, policies, and the registered manager's home improvement action plan. We also looked at training and recruitment records for five members of staff.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in February 2017 we rated this key question as requires improvement. This was because covert medicines were not being administered safely. Also, people told us they had to wait a long time to receive support. We found that improvements had been made with regards to covert medicine procedures. However, there continued to be negative feedback around staff response times.

The service was not always safe. There was inconsistent record keeping to evidence that guidance from healthcare professionals was being followed. Where people were at risk of choking, a referral was made to the speech and language therapist (SALT). The SALT guidance was stored in the care plan and for some people this included having their drinks thickened to a specific consistency to reduce the risk of choking. There were record keeping processes in place for staff to sign to confirm when they had used the thickener. These records were not maintained. For example, one person over a 13-day period, only had six signatures to confirm the thickener had been used. Another person over a 15-day period, only had eight signatures to confirm that the thickener was used.

We saw that people at risk of choking were not always supported by staff who understood their needs or the guidance that was documented in the care plans. We saw that one person, who had been assessed as requiring thickened drinks had a beaker of tea served at the morning drinks round. This drink had not been thickened at all. We advised the registered manager of what we had observed and action was taken to identify the staff member responsible and further training was provided. Another person was given a biscuit with their mid-morning drink. The person was in an awkward position and was not assisted to sit up safely to ensure good posture whilst eating. The front sheet of the person's care records located in their bedroom stated that the person required, "a soft moist diet." The records stated that a few days prior to the inspection the person was given a cheese sandwich. These textures conflicted with the information and SALT guidance recorded in the person's care plan. This left people at risk of choking.

There were gaps in people's care records. Pressure ulceration can develop when people are not supported to change their position regularly. At the inspection one person had a pressure ulcer. Recording processes for pressure ulcers were not always following best practice. Wounds were photographed, but details of the wound were not recorded. For example, where the wound was on the person's body, the size of the wound, or whether the wound improved. This meant that the staff could not evaluate the healing progress of pressure ulcers to provide the right care.

We found discrepancies in the repositioning records. We saw that people were not always repositioned as per their care plan. We saw records for one person that showed they had been positioned onto their back at 04:35am. On the same day, we saw the person was on their back at 11:15am. Records and a member of staff stated that the person should be repositioned every four hours, yet we saw and records confirmed that the person remained in the same position for over six hours. Records for other people also showed repositioning wasn't always consistent with guidance in their care plans. People who required repositioning every four hours, frequently went for periods of six to seven hours in the same position. This was usually in the morning after they had been repositioned at around 4am, the next recorded reposition would usually be at around

11.30am. This meant that people were at risk of developing pressure related health issues and sore skin.

After the inspection we had received information that two people had developed pressure ulceration. The local authority safeguarding team and tissue viability nurse investigated and closed their enquiries into these. No further concerns were raised following their investigations.

There were gaps in the administration records for topical medicines (TMAR), such as creams or lotions. For example, for one person, the instructions for their topical cream administration stated it should be applied "twice daily". We saw that staff were frequently only signing in the mornings to record administration. For another person, we saw that the directions for administration were conflicting between their TMAR and care plan. The TMAR stated the topical cream was to be applied once a day, the body map that accompanied the TMAR stated twice a day, and the care plan stated that the person was "self-caring." We spoke with the relative for this person who advised us that the cream should be applied twice a day and that the person was not able to safely self-care. This meant the service could not be sure people were receiving their required creams and lotions as prescribed.

This was a breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns around inconsistent completion of records were included in the registered manager's home improvement plan and action was in the process of being taken to improve compliance. There was an "embedment" date of 13 June 2018. We were advised following the inspection that in May 2018 it was acknowledged that "supplementary chart compliance is improving, but omissions are still being found on both units, despite all care staff receiving supervisions in this area."

We observed medicines to be administered safely, however we saw the potential for risks to occur due to the nurse being interrupted by external phone calls during the medicine round. The nurse received three external calls on the portable phone they had about their person. The interruptions increased the length of time it took to complete the medicines round as the nurse had to stop what they were doing, secure the medicines trolley and respond to the telephone enquiry. As the medicines round was interrupted, there was an increased risk that mistakes could be made.

We recommend that the service reviews current guidance around reducing interruptions for staff administering medicines and updates their practice accordingly.

Medicines were stored safely and records of administration were up to date, with no gaps or errors. Where people required medicines on an 'as and when required' (PRN) basis, there were PRN protocols in place. The protocols directed staff as to when to administer the medicines, for example, what symptoms the person may present with if they are experiencing pain.

People told us staff were not always available. Comments included, "You don't see them really, they [staff] are very busy. There are a lot of people who need a lot of attention", "It's always a long time for them [staff] to answer your bell, particularly in the mornings. You know you're going to be in for a long wait", "They [staff] can take a long time to come, I don't think it matters what time of the day it is, sometimes they explain why I had to wait, sometimes they don't", "The staff are under pressure and rushed. I can wait up to an hour to go to bed, or on the toilet. They need more staff."

Relatives were also concerned about staff availability. One relative said, "There isn't enough of them. They try their best, but there's too much for them to do. If you come of an evening, there's nobody around."

Another relative explained, "It started off alright, but it's not so good now. You come in the evening it's difficult to find anyone." Some relatives told us they visited daily because they felt this was the only way to ensure their family member received appropriate and safe care and treatment.

Most staff told us they felt there were not enough of them available to allow them to do their jobs to the best of their ability. One staff member told us, "There isn't enough staff to do everything that needs to be done, for example some people have dirty fingernails. Staff do their best though." Another staff member told us they felt the evenings were challenging due to staff levels. They said, "It is always very busy, especially in the evening. I think having that one extra person on duty in the evening would make such a big difference to us."

Visiting healthcare professionals told us there appeared to be enough staff, however this was based only on what they had observed from a healthcare perspective. One professional said, "The staff numbers seem to stay the same, but staff tell us there aren't enough of them."

Staff were not always able to respond to people's needs in a timely manner. We saw that one person was slipping from their chair and we alerted a member of staff. The member of staff tilted the person's chair backwards to prevent them from slipping further. They told us they were busy and said they would come back when they were finished and would then support the person to be repositioned. We also saw that another person was calling for help from their bedroom, becoming increasingly distressed. We had to find a member of staff and alert them that the person needed assistance.

Relatives felt that there were not enough staff to ensure their family member had enough to eat and drink. One relative said, "I don't think my [family member] gets enough help to drink. And because they are slow at eating, I don't feel the staff have the time or patience that I do." Another told us, "One of us will come in to help with lunch and drinks every day at lunchtime. It reduces the pressure on staff and makes sure that our [family member] has had at least one good meal and some drinks." One person told us they were thirsty, they had a full cup of hot drink and a cup of water on their over bed table, however these were not in their reach. We alerted staff to this and they then assisted the person after we had prompted. One relative told us their family member is frequently very thirsty when they visit and said their family member is at times "gasping" for a drink.

Staff were not always available to support people to drink enough or have access to drinks. We observed the mid-morning drinks round on both days of the inspection. We saw that drinks for some people were placed out of reach, or were placed next to the person without the support to help them have their drink. Some people's drinks remained untouched when checked throughout the day. This meant that while people were given a drink, they were not provided with the necessary staff support to enable them to have the drink. On the second day, we saw that the mid-morning hot and cold drinks were distributed. It was almost one hour later when a staff member began supporting people to have their drink. This meant that some people's drinks were cold by the time they received support.

We observed that people were left with dietary supplement drinks, and hot meals, without the support that they required. For example, on the second day of the inspection we saw that one person was in bed asleep while lunch was being served. A hot meal was chosen for them and placed on the table next to their bed. An hour later the person had been supported to their chair, but the meal remained untouched and was cold. The person also had two unfinished dietary supplement drinks on their table, prescribed due to weight loss. The person had been identified as losing weight, yet additional support from staff was not put in place.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The registered manager told us that a recent recruitment drive had been successful. They said that there were new staff waiting to start once recruitment checks had been completed. We discussed the use of agency staff with the registered manager, they said that there was "difficulty recruiting nurses." They told us they try to use the same agency staff to provide consistency for people. In response to concerns around staffing levels and waiting for new staff to join the team, the registered manager told us they had paused admissions to the service. They said, "We have to ensure safe staffing levels." The registered manager told us staffing numbers were based on assessments of people's dependency needs. We discussed that although the service may be maintaining their staffing levels in accordance with the dependency calculations, improvements were needed in how staff are deployed throughout the day.

We checked staff recruitment files and found that the recruitment processes minimised the risk of unsuitable staff being employed. These included seeking references and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and reduce the risk of unsuitable people working with vulnerable children and adults.

Staff understood their responsibilities to identify and report abuse. One staff member told us, "People here are really vulnerable, so they need us to keep a close eye on them to ensure their safety." Another staff member said, "We know people, so we pick up easily if there's something wrong. I would always report anything I was concerned about." Staff told us they had received safeguarding training and that they were confident the registered manager would act upon concerns raised.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection in February 2017 we rated this key question as good. At this inspection we have found that improvements are required.

The service was not always effective. Staff could tell us about the principles of the Mental Capacity Act 2005 (MCA). The 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 legally authorised under the MCA. We saw that people who lacked capacity to consent to receiving care and treatment had been assessed and best interest decisions were in place.

Although staff understood the principles of the MCA, this was not always evident in the care records. We saw daily records that consistently stated tasks were done to or for people "in their best interests". For example, "Checked in best interest. Pad wet. Washed and changed. Resettled on back." The addition of "best interest" to care records was a habitual record keeping practice, rather than reflective of the care delivery we observed. During the inspection some nursing staff were receiving care plan and record keeping training. We were advised that this would be addressed as part of the training.

Staff did not consistently talk to people, explain or involve people in decisions. People were taken to the dining room from the lounge for their lunch time meal. They were not asked if this is what they wanted to do. For example, at lunch time one staff member said, "I'll take her. Hello [person]. It's [name of staff member]". The staff member then pushed the person in their wheelchair out of the lounge. They did not inform the person that they were moving or where they were going. The staff member then stopped, applied the brakes to the wheelchair and walked off. They did not inform the person why they were leaving them or what was happening. We heard staff discussing with each other where people should sit, rather than people being asked. For example, one staff member told another, "[Person's name] goes first as she sits at the back of the dining room."

People were brought into the lounge after their meal, but not asked where they would like to sit. Staff brought one person to the lounge in a specialised chair but had difficulty moving it between people. They and other staff moved people in their wheelchairs or specialised chairs, to accommodate the person. They did not inform them of what they were doing or ask permission. One relative further confirmed that people are not offered choices. They told us, "Staff don't speak to people. They just park them wherever [the staff] want to put them."

This was a repeated breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived on their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the

Deprivation of Liberty Safeguards (DoLS). The management team had submitted DoLS applications where appropriate. The DoLS applications were reviewed regularly to ensure they remained relevant and there were records of correspondence with the local authority in the event of any changes.

The environment and premises were not always appropriate in meeting people's care and support needs. For example, corridors and doorframes were narrow. We saw staff struggling to manoeuvre large wheelchairs through some doorframes, instructing people who did not always have the physical ability to "tuck [their] arms in." Storage rooms had been created by changing bathrooms into storage space for hoists and shower chairs. One bathroom was used to store the laundry trolley and another short metal trolley. The trollies had to be moved out of the way when people needed to use the facilities. In the ground floor dining room, people were strategically placed because of their large wheelchairs, to ensure everyone could fit in the room. This meant that some people in large wheelchairs were positioned sideways and they were not facing other diners at the same dining table.

People were positive about quality of the meals and the choice of food available. One person told us, "I'm quite fussy, I don't like certain things, they've been very accommodating." Another said, "The food is wonderful, plenty of choice, you can ask for other things if you don't like what's on the menu." One relative told us, "The food is excellent and delicious. The caterers will be flexible as my [family member] likes eggs, so they will do an omelette or scrambled eggs instead of what's on the menu, and [family member] is then more likely to eat it." The chef told us, "If the residents want something different, I will cook it." They told us that snacks are available throughout the day, including biscuits, milkshakes, cakes and crisps.

There were reminiscence boxes on the walls in each bedroom. These contained ornaments, photographs, or articles of relevance and important to people's history or interests. The boxes helped people identify their bedroom, as well as reminders about the things that were important to them and events in their lives.

People and their relatives or visitors told us they had been involved in their assessments prior to and during their admission at the service. One person said, "I was able to tell [staff] about myself, what I like and dislike before I came here." Another person told us, "I did answer a lot of questions about what I need and what I prefer to do, that was when I first came here." One person's relative said, "I feel involved, I've been able to write a 'this is me' document and explained my [family member's] likes and disliked when they first came, as well as when things change. It is ongoing." Another relative explained, "I recently re-wrote information [for staff guidance], because I felt it had been lost along the way, just to make sure they knew all about my [family member]."

There were transfer documents in place, for completion at the time of a person being admitted to a hospital or another service. The format contained key information, such as contact details of relatives, the person's medical history, the communication and support the person required for eating and drinking. One staff member told us that they would attach a copy of the person's medicine administration record, and their treatment escalation plan to ensure maximum information was provided.

We saw that people were being visited by their GP. The registered manager told us they worked closely with the GP surgery and hospital. The service was near these services. One person had an audiology appointment during the inspection. Their relative told us, "The staff arrange all of these things. They're very good. We thought we would have needed to arrange it and take her, but they did it all." There was also evidence in people's care records that people had seen a dentist.

We received positive feedback from the healthcare professionals we met during the inspection. One professional explained, "The nurses are excellent. They are good with helping people to meet their goals."

Staff training records confirmed that staff completed their induction training and received regular training updates. This included training around safeguarding, MCA, record keeping and infection control. Staff told us they received enough training to equip them with the skills to do their job. One nurse told us, "We have a lot of training. I have had clinical skills training and tissue viability nursing training recently."

Requires Improvement

Is the service caring?

Our findings

At the previous inspection in February 2017 we rated this key question as good. At this inspection we have found that improvements are required.

The service was not always caring. Staff had limited time to spend with people so were task focused. One relative told us, "Staff have their to-do list in their mind, so they miss other things about people. They are always having to think of the next job, but running late with people's personal care." Another relative said, "Staff do things so quickly as they don't have the time, they often don't check they have made the bed properly."

We observed staff say to people "see you later", when they assisted people into the lounge and for some people the staff simply walked away without saying anything. Staff did not consistently check if people were comfortable, or if they needed anything before leaving them. One relative told us, "Staff put people in front of the television, but don't always pay attention to what they have left them watching. I came in one day and there were monsters on the TV and it was so loud. I don't think staff had even considered that people might have been frightened." Another relative said, "They brought one person in one day, who was slumped in their chair. They looked so uncomfortable, but staff didn't seem to notice."

One person told us, "Things have changed here. It used to be more genteel and now the staff shout to each other up and down the corridor. It was more like a library and now it's more like a noisy fish market." We heard loud conversations between staff, in the corridors, talking about people as tasks they had to complete. These conversations were often while supporting other people. For example, one staff member called out, "I'm just doing [person's name] personal care. Can you start dinner?" The staff member didn't engage with the person they were supporting. We also heard one staff member say loudly in the corridor to their colleague, "I still have [person's name], [person's name], and [person's name] to do." People's care was therefore being discussed in an undignified manner and could easily be overheard by others.

People's privacy was not always respected. We saw that staff entered people's bedrooms throughout the day without knocking. On one occasion three staff entered a person's bedroom without knocking and introducing themselves. One person told us, "The staff don't always knock on the door. When you're new here they'll do that and wait until you answer. But as I've been here quite a long time, they just come in without waiting to be asked."

We observed instances where people's rights were not respected. Examples included a lack of consideration for people who lived in rooms opposite the care office. The care office door creaked loudly and was often allowed to slam shut as staff entered and left. Staff had not considered how intrusive the noise was for people living in close proximity. We observed people living near the care office were being supported in their beds day and night. The loud creaking noise was addressed during the inspection by the maintenance member of staff.

People's dignity was not always promoted. For example, we saw that the tap for one person's catheter was

left on show below their trousers. We saw that some people appeared unkempt in appearance. One person was calling for assistance and this could be heard in the corridors. There were no staff present to attend. The person was in a state of undress with their bedroom door open and we had to find a member of staff to inform them that the person needed their help.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People provided us with mixed feedback about whether they felt the service was caring. Some people felt that staff time was too constrained to allow them time to talk. One person said, "I can chat to them. We've got pretty good relationships and they'll ask about my family. But they have very limited time to talk with me." Another person told us, "The staff are kind, but I'm not sure if they would notice if I was upset to tell you the truth." And, "I get on alright with them, but they definitely don't have time to chat."

Some positive comments about how the staff cared from relatives included, "The night staff are especially nice to my [family member]." As well as, "Staff are always happy and welcoming. Mum has her favourites, who she is very fond of. We can come in at any time. They don't mind." Other people's relatives told us they were welcome to visit at any time. One relative said, "You're welcomed any time day or night. We were told by staff to come whenever you want to, stay all day, or just a few minutes, treat it as you would your [family member's] home."

Negative feedback from relatives included, "There are lots of posters about kindness on the walls. It's the kindness of staff at all levels that we don't get to see." Also, "People are like a commodity here. Routines are organised for the staff and not for the people living at the home. Staff don't notice if someone has spilt food or drink on their top. It's never changed."

We were advised by the management team that a survey completed by people and relatives evidenced that "85% of residents surveyed felt the staff were kind. 93% of relatives surveyed scored staff a good/excellent when it came to kindness." These responses differed to the feedback we received from some relatives.

Some relatives told us the staff knew their family member well. One relative said, "They see beyond the more challenging behaviour, which we know can be difficult, and they still like the person [my relative] underneath that. Another relative told us, "They are kind, for example the activity staff have taken the trouble to find out all about my [family member's] working life and researched and printed information off from the internet. They've laminated it so that people can show [my family member] and talk about it with them."

People who were cared for in their rooms, or who spent time in the first-floor lounge, received very little interaction from staff. One relative told us, "People are just parked and lined up in the lounge. There's no interaction. No conversation. They're then moved to the dining room for their meal and moved back to sit in the same place." We saw staff walk past the first-floor lounge but they avoided communicating with the people unless there was a task related need.

On the ground floor activities took place and people were engaging with the activities coordinator. The coordinator knew each person well and remembered their usual preferences when drinks were offered. The activities were calm and people appeared to be comfortable in the company of the coordinator as they conversed together with relaxed body language. One person who had chosen not to partake in the activities told us, "The staff don't interfere with my independence, they know I'm not a group person and that I prefer to stay in my room. They respect that."

The registered manager told us that people had been supported to attend family events outside of the home. They told us that one person had attended a relatives wedding. They were supported by two members of staff who accompanied them during the day.

One person was reluctant to leave their room; however, they were happy to do so if accompanied by the maintenance member of staff. The registered manager explained that the maintenance staff member saw that the person connected well with them. They now stop by the person's room when possible during the week and they will go for a walk around the service and garden, or will have a hot drink and a chat together.

People's rooms contained their own decorative items such as ornaments or photographs, as well as items of furniture if they wished to have these with them. One person told us they had set up their own bird table in the garden by their window. They said, "I love birds and they said it was alright to bring it and put it there, my family fill up the feeders and I get squirrels and all sorts of birds coming to it."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in February 2017 we found that this key question required improvement and we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the necessary improvement had not been completed so we found a continued breach of Regulation 9 of the Regulations.

Due to the change in provider, the care plans were being re-written using new documentation and formats. The registered manager told us that this should be completed by December 2018. At the time of the inspection two different systems were being used. Most of the care plans in use were out of date. Staff had to read through over one year's worth of monthly updates to find out the person's current needs. This meant that staff were at risk of missing information important to the care of that person.

Care plans were mostly task focussed and information did not provide staff with appropriate guidance. For example, one person's 'Going to the toilet' care plan stated that they would "like their continence pad changed after a bowel action." The information did not state if the person could alert staff to their need, or if staff needed to check regularly. The care plan also stated "Constipation Senna. Action should be encouraged to increase fluid intake and she's prone to urinary tract infection (UTI). Needs laxatives to be given regularly and should be given a high fibre diet." We spoke with chef, who was not aware of the person's recommended high fibre diet. In addition, the care plan did not show how these interventions were monitored to ensure they were effective. The person had a UTI in February 2018, but the care plan had not been updated in response to this. An oral care assessment stated "yes" and "no" to whether the person needed help to clean their teeth. There was no further detail to describe what support if any, was needed. This meant that staff reading the care plans would not be able to quickly access adequate information that would help them support the person.

Daily record entries were task orientated and did not show a person-centred approach to everyone. Examples of entries we saw in care plans included, "Transferred to bed. Wet, washed and pad changed." As well as, "Checked, pad changed, lunch delivered in her room." This did not explain how the person was involved in the decisions affecting their care.

We received some positive views from people and their relatives about the standard of personal care. One person said, "I get the help I need with my legs and feet, doing up buttons and putting in my hearing aid. I can have a bath when I want one, they put you on the list, we agree a time and it gets done." One relative told us, "It's a tribute to their care here that my [family member] hasn't had any skin breakdown." Another relative said, "My [family member] is always clean, well looked after and comfortably positioned in bed."

For one person, we saw that their teeth/denture care record was completely blank for the whole of May 2018. Their personal hygiene record had 13 entries which were either "R" or "D", to indicate that the person refused or declined, the rest of the days were left blank. The care records for another person showed that they frequently declined to have a bath. The person's relative told us, "It isn't that [my family member] declines as such. They only ask [my family member] when they get a spare half an hour in the afternoon. [My

family member] doesn't want to then have to get undressed and re-dressed in the day, when they are already dressed." The relative explained, "[My family member] just needs to be offered a bath at an appropriate time in the day. They say [my family member] declines, but bath times are not offered to meet people's needs, it is based on staff convenience."

People did not always receive care that was responsive to their needs. Records showed that one person had diabetes and had their blood glucose levels monitored on a daily basis. It was recorded that the normal parameters for the person were between six and 10 but there were a range of entries which showed the levels were outside of this range. This included levels of 14, 12.5, 13.2, 4.4 and 4.6. Records did not show what action was taken or what measures were in place to ensure the persons wellbeing. The person had a plan regarding their diabetes which showed the person could inform staff if they were feeling well. The plan did not give details of how the person presented if unwell, to assist staff in identifying and addressing any ill health. The plan stated the person needed staff to assist with choosing an appropriate diabetic menu. There was no associated guidance to assist staff in doing this.

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

Most people told us they felt they could go to the registered manager if they had a complaint. One person said, "Overall, I'm happy and there are no major issues, but I'd feel able to talk to the [registered] manager if there was something wrong." A relative told us, "If I've got concerns, I see [the registered manager] and I find them very approachable and willing to listen."

Some people and their relatives told us they either did not feel they could raise complaints with staff, or were unhappy with the responses they had received when they had raised concerns. One person told us, "I wouldn't complain to the staff, because they're busy and they haven't got the time." A relative said, "I saw the registered manager about the noise levels, due to staff shouting in the corridors. I was offered a quieter room, which wouldn't have suited my [family member] who likes to see people passing by. I would rather that the noise just be reduced, so I wasn't fully satisfied with the response." A different person's relative said, "I feel like I'm always complaining, but they are my loved one, so I care deeply about them and want the very best. It upsets me." They told us they had discussed concerns with the registered manager previously, and said they did not feel everything would be resolved.

The service supported people with impairments that meant they may not be aware of the complaints procedure. The registered manager was asked if there was an easy-read complaints procedure that people had access to. The registered manager told us they didn't have one to hand, but said, "I'm sure we have one online somewhere". This meant that this information was not readily available to those who may benefit from it. Therefore, the service did not fully comply with the Accessible Information Standard (AIS). The AIS 2016 was introduced by the government to make sure that people with a disability or sensory loss are given information in a way they can understand.

Prior to the inspection we received concerns from a whistleblower two months before we inspected. We raised the concerns with the area manager by email before we inspected. The quality manager visited unannounced the following day and made subsequent visits on three other dates with the area manager. The response we received from the area manager contradicted evidence that we found during the inspection. For example, the complaint raised concerns that people were not helped with personal care and that preferences for baths or showers were not given, because of a lack of time and staff. The area manager responded to this by stating, "As part of our visits we looked at home routines, staff allocation and discussed best practice in terms of person centred care. We also reviewed a few care plans and supplementary charts

to evidence care is planned and given as required and found no issues."

We found evidence of poor record keeping and out of date care plans. We saw people not receiving care that had been assessed as being required. Staff told us that staffing numbers meant that people did not receive sufficient personal care. One staff member said, "If there is enough staff, personal care gets done before lunch." Another staff member told us, "Staffing is an ongoing issue and it means sometimes personal care is done later than people want it." The registered manager told us that they were aware of record keeping issues and stated it was a "staff compliance issue". This evidenced that concerns were not responded to in an open and thorough manner by senior management at the service.

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

We reviewed records of the complaints that had been recorded as received. We saw that there were investigations into each recorded complaint. The themes raised in the complaints were around drinking water not being easily accessible, used crockery left in people's rooms, difficulty locating staff when needed, and relatives not being notified of sore skin areas. For quality assurance purposes, complaints were sometimes investigated and responded to by another home manager within the organisation.

We reviewed call bell response times were audited and reviewed. The registered manager told us that they had identified that some people were waiting too long for their bells to be answered. Changes were made to improve the response times and these were reflected in the wait times.

Each person had a section in their care plan regarding end of life wishes. The plans contained information such as wanting to stay at the home, with family. One plan stated the person would like a special picture nearby. The plan stated the person did not like medicines but this was not explored further to ensure any pain would be properly managed. The service received compliments from relatives about people's end of life care provided to their family member.

The wellbeing coordinator told us they arranged a range of activities each week based on what people enjoyed and what appeared to have worked well previously. They said people were given a weekly copy of the forthcoming activities. The wellbeing coordinator said they thought it was important for people to "see the outside world" so arranged trips out as much as possible. They said last week people had gone to the pub for a meal. They said there was also a strong focus on the local community. Children from schools and nurseries visited and there was also a pet as therapy (PAT) dog, people enjoyed. PAT dogs are animals that have been trained and assessed as suitable to visit people in hospital or care homes. Activities were adjusted to people's wishes. For example, one person was not an "animal person" so was not visited by the PAT dog. Another person had always kept dogs so gained a lot of benefit from them. The wellbeing coordinator said they often put dog treats on the person's shoulder so the dog would nuzzle into them, which the person loved. Other activities involved alpacas which toured the home and eggs so people could watch them hatching and hold the new chicks. They said they helped some people keep in touch with relatives by using email or Skype, particularly if they were away on holiday.

Two relatives spoke of activities such as the alpacas, the chicks and PAT dog. They said they felt there was a lot for people to do if they wanted to join in. Another relative said the wellbeing coordinators were "good but spread too thinly." They said at weekends the activity was "films", but these were rarely put on and people weren't really interested in them anyway. They said their family member was often "bored and at times suffered social isolation." Due to not having anything to do, the relative said their family member went to bed early, which is something they never did.

During the inspection, beauty therapists visited to offer treatments such as hand and head massage. A quiz took place which people engaged with well. In the lounge there were flower pots and bird boxes people had decorated. They had also decorated photo frames and had placed a photo of them inside.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in February 2017 we rated this key question as good. At this inspection we found breaches in regulation and areas requiring improvement. Therefore, the rating has changed to requires improvement.

People's relatives shared concerns with us that they did not feel the provider was investing in making improvements to the home and the environment. Also, while we received some positive feedback, there were other relatives that told us they did not feel the registered manager had an overview of the issues impacting the quality of care their family member received. Comments included, "I don't have confidence in the registered manager. They don't really speak to you." And, "You walk past their office but they rarely say hello or come out to see you." As well as, "The registered manager is not really a people person, whereas the others are." The registered manager explained that they had been absent from the service for a period of time. We also discussed that the deputy manager was not always recognised as being part of the management team, because the uniform was the same as the care staff.

The service was in a transitional period, with a changeover in provider. The registered manager, and deputy manager were in post prior to the changeover. 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 registered manager told us their biggest challenge had been supporting staff through the changeover in provider. They said they had been completing supervisions, as well as the deputy manager, to discuss how staff support people during this period. The registered manager explained that they also discussed the new paperwork with the staff during the supervision. This included reminding the nursing staff that they should check the completion of supplementary charts and daily records.

There were changes to the senior management structure, above the registered manager. The registered manager told us that their senior management were "still finding their feet" and that they were not yet an "established team". The registered manager told us they felt that they could pass their feedback to their senior managers and that they felt the feedback would be responded to supportively.

Audits were completed in different aspects of the service; however, they were not effective as they did not identify all the serious issues we have found. Where audits had been completed the information was used to develop the registered manager's 'home improvement plan'. We saw that shortfalls for example in record keeping were identified in the audits, these then were added to the home improvement plan. The registered manager told us the shortfalls were because of staff not taking accountability for this part of their role. During the inspection care plan training was taking place, as part of the training the staff were being reminded of the importance around accountability and record keeping.

The registered manager told us that they had requested approval from the provider to employ "host and

hostess" staff. Their role would be to support people during the morning and afternoon drinks rounds, but to also support during the meal services. The role would not include care duties such as personal care. Although recruiting for a host/hostess was included in the registered manager's 'home improvement plan', the impact on people around not having enough to drink had not been identified.

Infection control audits didn't identify the importance of surfaces needing to be wipeable to prevent the spread of infection. We raised concerns with the registered manager and quality manager that some parts of the environment could not be cleaned effectively and that these posed an infection control risk. The registered manager received confirmation from their head office that the sluice rooms would be refurbished.

Systems and processes to assess, monitor and improve the quality of the service were not robust and had not identified the issues we found during this inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager discussed plans for changes to the environment. They said that four rooms would be decommissioned and turned into storage rooms. We discussed the poor maintenance of the décor and the registered manager explained that previous choices during the last refurbishment "didn't make for the easiest upkeep". There were plans to change the colours and repaint areas of the service. We were advised that the handrails throughout the service had recently been replaced. The registered manager told us that the redecoration was not considered a priority by the provider at this stage.

We also discussed changes to the type of support provided at the service. The registered manager had introduced intermediate care beds. These are short stay admissions to the service, for people who require time to rehabilitate following time in hospital. The registered manager said that over time the service would look to gradually introduce this service more as it was working well. They told us, "It is nice to see people get well and be able to go back home."

With the changeover in provider, the registered manager told us there was a changeover in the systems used. They explained that HC-One have a thorough complaints investigation procedure and that this would provide the service with more support to respond to complaints thoroughly.

We received positive feedback from staff about the support they receive from the registered manager and deputy manager. One nurse told us, "The manager is good. If I have a problem I can go to them. The nurses support me and the registered manager does the supervisions and appraisals." The registered manager said, "The only way a home can do really well, is the staff. We are very proud of them. We receive lots of positive feedback about the staff."

The registered manager described their management style as, "Supportive to the staff as much as possible. I'd rather speak with the people face to face to discuss any issues and find out the reasons for their concerns. I think people and staff find me approachable. Staff feel 100 percent supported by me." They told us they coached nursing staff using their own nursing experience to "make sure their clinical skills are up to scratch". They said they then support the nurses to "lead the teams" and that "nurses need to be the decision makers". The registered manager explained, "The management team are very passionate about care and we try to anticipate any problems. We are now at a point in the transition [between providers], where things are getting more comfortable."

When recruiting new staff, the registered manager said they ensured they employed the right people from the start, by getting to know people's aspirations. They explained that they ask the candidates to complete

written questions in their interview, to find out more about them. The registered manager said, "We want people who are enthusiastic. We want staff to want to work here. I like to employ people who want to develop their skills and career."

The registered manager told us staff documented any accident or incident and gave it to them to review. These were added to the electronic system and any required action or "lessons learnt" were undertaken. All accidents and incidents were passed to senior managers for review. They ensured all necessary action was taken or suggested alternatives or further action. This information was then used to analyse potential trends such as how many falls occurred at a time of day. There were monthly meetings to consider any falls, the circumstances leading up to them, lessons learnt and what could be done to prevent further occurrences.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care provided was not always appropriate and reflective of people's preferences. Care plans did not reflect people's current needs so that these could be met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not always treated with dignity and respect. People's privacy was not always maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Where risks had been identified the service had not always ensured that care provided mitigated those risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The service had not maintained an accurate, complete and contemporaneous record in respect of each person. There were gaps in recording which meant there was not complete records of care delivery. Systems and processes to assess, monitor and improve the quality and safety of the service were not effective or

robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff deployed to meet the needs of people.