Fulford Care Home Limited

Fulford Care & Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 5 and 6 October 2017 and was unannounced.

This inspection was the first inspection since a change of provider in December 2016. The inspection was planned because we had been made aware of a number of safeguarding issues communicated to us directly and received from the local safeguarding authority. Our inspection does not examine specific incidents and safeguarding allegations. However, we used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection.

Fulford Care and Nursing Home is registered to provide nursing care and residential care for up to 74 people with a range of care needs, including frailty of old age, specific health conditions and people living in the early stages of dementia. At the time of our inspection, 50 people were accommodated at the home. Fulford Care and Nursing Home is divided into four units, Magnus, Harold, Edmund and Godwine. Communal facilities include the main lounge on the ground floor and a smaller lounge on the first floor. There is a large dining room located in a converted barn and a ground floor conservatory. All rooms have profiling beds and are en-suite. People have access to gardens surrounding the home.

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

People's risks were not identified, assessed or managed safely. Risk assessments provided incomplete information about people's risks and insufficient information and guidance for staff on how to mitigate risks. Daily records in relation to completion of fluid intake or repositioning charts for people, had not always been completed fully. Personal emergency evacuation plans were not in place for everyone living at the home. Some aspects of medicines management were unsafe. The medicines trolley was left unlocked and/or unattended when medicines were administered to people. Medicine profiles for people were out of date, although staff were in the process of taking new photos of people.

Staff were not deployed in such a way as to ensure people's needs were met promptly. Many people were still in bed or sat in their rooms in their nightwear at 11am awaiting personal care. A medicines round which had begun at 8.30am was not completed until 11.15am. There was mixed feedback about the staffing levels, with some relatives and staff expressing concern about the high usage of agency staff.

Staff had not received regular supervision meetings or appraisals of their work. Competency assessments for nursing staff had been completed in some cases, but information was scant and did not cover all clinical competencies. Staff completed a survey in July 2017 which indicated they were unhappy with the level of support they received at that time.

Assessments of people's capacity, in line with the legal requirements of the Mental Capacity Act 2005 (MCA), had not always been completed. Some people had been deemed to lack capacity, but had no capacity assessments in place to corroborate this. People's consent to care and treatment had not been formally recorded, nor was it clear how people's particular communication needs had been assessed or were met.

There was no evidence to confirm that people and/or their relatives were involved in planning and reviewing their care. Care plans did not always provide detailed information about people's care needs or have social histories that staff could access. Staff and management acknowledged that care plans did not always contain updated information about people or that they were reviewed regularly. Care staff told us that they relied on handover meetings to share information about people's care and support needs. However, handover sheets did not provide detailed information about people and staff commented that this would be of concern for new or agency staff who did not know people well.

Systems had not been established to identify areas of improvement. Some audits that were in place were not effective, for example, in relation to care plans or with hospital admissions. Care records were not always stored securely so that confidential information about people was not protected.

Signage or contrasting colours had not been utilised effectively within the environment to enable people to navigate around the home.

Some positive caring relationships had been developed between people and staff. People had mixed views about the staff who cared for them. Relatives spoke positively about the caring nature of staff. As much as they were able, people were encouraged and given choices in relation to day-to-day decisions with their care. Apart from one incident we observed, staff treated people with dignity and respect.

Health and safety audits were completed as needed and checks made on the safety of equipment, electrical installations and gas safety. People felt safe living at the home. Staff had been trained to recognise the signs of potential abuse and knew what action to take. Safe recruitment practices were in place. Aside from the issues above, medicines were managed safely.

Staff we spoke with understood the requirements of the MCA, although not all staff had completed this training. Staff completed training in a range of areas including safeguarding, moving and handling, basic life support, dementia awareness and health and safety. New staff followed the Care Certificate, a nationally recognised qualification. Staff meetings took place from time to time and records confirmed this. There were mixed views about the meals on offer. We observed that people did not always receive the support they needed from staff in order to eat their meals. Special diets were catered for. People received support from a range of healthcare professionals and services.

Staff had a good understanding of person-centred care. A range of activities was organised for people at the home and an activities co-ordinator helped to arrange and deliver these. Complaints were managed in line with the provider's policy. People and their relatives knew who to talk with if they had any concerns or wished to make a complaint.

Accidents and incidents were reported and monitored to identify any patterns or trends. People and their relatives were asked for their views about the service and actions taken where needed. Staff we spoke with felt supported by the management and leadership of the home. Some people and their relatives did not feel the home was well led.

Following the inspection, an operations manager sent us information on the actions that would be taken to

address the issues and concerns we found at inspection.

You can see what action we have asked 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

Some aspects of the service were not safe.

Risks to people were not always identified, assessed and managed safely. Risk assessments did not provide sufficient detail or guidance for staff on how to keep people safe. Staff were not deployed in such a way as to ensure people received care and support in a timely fashion.

Medicines were not always managed safely.

Staff had been trained to recognise the signs of potential abuse and knew what action to take. Safe recruitment practices were in place.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff did not receive regular supervision or annual appraisals. Consent to care and treatment was not always sought in line with legislation and guidance. Not all staff had completed training on mental capacity, although they did understand the requirements of the legislation.

New staff completed an induction programme and were encouraged to study for additional qualifications. All staff completed a range of training considered essential for their role.

People and their relatives had mixed comments to make about the food on offer. Menus were varied and special diets were catered for. People had access to a range of healthcare professionals and services. The home did not utilise signage or contrasting colours to enable people living with dementia to navigate their way around the home.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Positive, caring relationships had been developed between some people and staff. However, we observed instances where staff

were not so caring or did not treat people with dignity and respect.

Staff engaged with people and encouraged them to make decisions and choices about their care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People and their relatives were not always involved in planning or reviewing people's care. Care plans contained insufficient information and guidance to staff on how to support people in a person-centred way. People's likes, dislikes, preferences and social histories had not always been recorded.

A range of organised activities was on offer. Complaints were managed according to the provider's policy.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Systems were not in place to ensure robust monitoring and measuring of the care delivered. Care plans were not always stored securely. Confidential information had been left out.

Staff felt supported by management and commented on the changes made since the new provider took over. People and their relatives were asked for their feedback about the service through questionnaires and at meetings.

The provider had submitted action plans and updates on steps that had been taken to address the concerns we raised at inspection.

Fulford Care & Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 5 and 6 October 2017 and was unannounced. The inspection plan was informed, in part, by partner agencies notifying CQC of safeguarding concerns in relation to this location. This inspection did not examine the circumstances of the specific allegations made. Two inspectors, a nurse specialist and an expert by experience undertook this inspection. 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 inspection was carried out due to information shared with us by West Sussex County Council Adult Services. The information shared relates to aspects of the management of care and nursing needs for people who live at the service.

Prior to the inspection we reviewed the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) since the inspection was planned at short notice. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We observed care and spoke with people and staff. We spent time looking at records including seven care records, five staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with nine people living at the service and spoke with three relatives. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, two operations managers and a quality assurance manager employed by the provider, three registered nurses, a care manager, two senior care staff, a chef and the maintenance man.

This is the first inspection since the new providers took over in December 2016.

Requires Improvement

Is the service safe?

Our findings

Risks to people were not always anticipated, identified or managed safely. Risk assessments are documents used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to people. Risk assessments should include guidance for staff on how to support people safely. Risk assessments we looked at were incomplete and did not provide detailed guidance to ensure people's risks were managed safely. For example, we read that one person was doubly incontinent with an associated risk recorded that skin damage would develop rapidly if support required was not maintained. This was insufficient. There was no guidance for staff about how to mitigate the risk of pressure damage or the level of risk. For the same person, we read that they required to be fully hoisted, with an associated risk of sustaining fractures. A falls risk assessment completed in July 2017 recorded this person was at high risk, but there was no further information to guide staff on how to move the person safely, except for a moving and handling assessment. In addition, we noted that risk assessments were to be reviewed monthly, but this person's risk assessments had not been reviewed since July 2017.

We looked at how people were looked after if they sustained a fall and the reports that had been completed by staff. One person had an unwitnessed fall resulting in an injury to their head. Staff discovered the person on the floor and completed a range of observations including blood pressure, pulse and temperature monitoring. The accident form and daily care notes for this person recorded that observations were taken at the time the person was found. Paramedics were called and undertook two further sets of observations, including neuro observations. In this person's care notes, we saw that a referral was made to the falls team and that on 17 August 2017, no response had been received. This person was known to be at high risk of falls and sustained a head injury and a skin tear on two consecutive days in October 2017. There was no evidence to show that advice had been received from the falls team or that the referral had been chased up. Food and fluid charts had been drawn up for this person and some entries were recorded. On two days in October, we saw that the total amount of fluid consumed by this person had not been recorded, making it difficult to establish whether they were drinking in sufficient quantity or not.

We asked to see the care plan for this person, but the registered nurse was unable to find it. We discussed this with the registered manager and with an operations manager who said, "I don't know why the care plans are not in place. She did have one; it must have gone missing". By the end of the day, a health and welfare assessment form had been completed which contained brief information and we were given a copy of this. Following inspection, an operations manager sent us an email which stated that the person in question was not a nursing resident and therefore that their clinical needs would be overseen by community clinicians, not nursing staff at the home. The operations manager added that the paramedics and GP were happy with the observations that had been completed by staff following the fall and head injury. We were told that since inspection, the person's care plan had been reviewed, along with the necessary assessments. The loss of the care plan meant that care staff did not have any written information about this person made available to them about how to meet their care and support needs safely.

A care plan and associated risk assessment for one person did not provide accurate advice or guidance to staff. This person had occasional seizures, however, the last seizure recorded had been in February 2017.

This person's care plan had not been reviewed since May 2017. In addition, the epilepsy care plan advised staff to call an ambulance if a seizure exceeded five minutes and to administer rectal diazepam if the person was unresponsive in excess of 10 minutes. This is incorrect as the diazepam should be administered first, then an ambulance called. The care plan also advised that if a head injury was suspected, neuro observations should be completed and a GP or paramedics notified of any abnormal readings. However, this person received residential care and we were told that neuro observations were only carried out, if needed, when people were funded to receive nursing care. People with residential care needs received support from community health professionals'. We also saw that this person had sustained a number of falls over the last few months, some of which were unwitnessed. We were told that this person could sometimes place themselves on the floor and that a fall may not necessarily have occurred. There had been no recent support from relevant healthcare professionals in relation to the management of this person's epilepsy. An operations manager acknowledged there was a need for this person's care plan to be fully reviewed as a matter of priority. In the meantime an emergency seizure plan had been put in place.

We saw that Personal Emergency Evacuation Plans (PEEPs) were in place for some people, but not others. PEEPs provide information to staff on what action should be taken with people should the home be required to be evacuated in the event of an emergency.

In our feedback from which was completed and given to members of the management team at the end of the second day of our inspection, we recorded that risk assessments were either not evident or did not provide sufficient guidance. After the inspection, an operations manager stated that there were gaps in risk assessments but that every person had an up to date Malnutrition Universal Screening Tool (MUST) assessment and Waterlow assessment; sample records were sent to us to confirm this. Waterlow assesses the risk of developing pressure areas. We were also told that every person had a nutrition and hydration assessment, together with mobility support plans and falls assessments. It was planned that care plans and associated risk assessments should be reviewed as a priority in the interim. We found that people were at risk of potentially unsafe care and treatment because their needs had not been properly identified or assessed.

We observed medicines being administered to people by a registered nurse during the morning. Medicines were dispensed from a medicines trolley. When left unattended, the doors were closed by using a catch on the handle, but were not locked. We saw that the medicines trolley was left unattended in the hallway whilst the registered nurse went to give people their medicines in the lounge. The trolley was also left unlocked and unattended when left outside the dining room, whilst medicines were taken to people who were sat at the dining tables; the trolley was again left unlocked when the registered nurse went upstairs to answer an emergency bell.

Some people did not have a medication profile or had an old profile from the previous provider of the home. Photos of people where taken needed updating, although staff told us they had just started taking new photos. Out of date or inaccurate information relating to people's medicines could be misleading for staff and put people at potential risk, as their most up-to-date medicinal needs had not always been recorded and were open to misinterpretation. We looked at a Medication Administration Record (MAR) for one person which showed that a transdermal patch had been applied. However, the patch positioning record had not been completed at the same time as the MAR. It is good practice to record this type of information to show which part of the body a patch has been affixed to or removed from.

The above evidence shows that people did not always receive safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, 50 people were living at the home. They were supported by three registered nurses and 11 care staff in the morning, two registered nurses and eight care staff in the afternoon and two registered nurses with four care staff at night-time. At the time of our inspection, according to the staff rota, there were 10 care staff allocated to the morning shift and five staff at night. We were told that staffing levels fluctuated based on people's care needs which were assessed using a dependency tool. We looked at the staffing rotas which showed that staffing levels were consistent across the time examined. There were sufficient staff to meet people's needs, but staff were not always deployed effectively.

We asked people whether they felt there were sufficient staff on duty to meet their needs and received mixed feedback. One person said, "There's not enough staff, so they have very little time to get to know their particular patients. I've had to wait a long time for the toilet". Another person told us, "Staff come fairly quickly, you wait a few minutes". A third person said, "They come pretty quick; they're a pretty good bunch". A fourth person told us, "I fall and they are very concerned about it. I can walk, but they say I have to have someone with me. I find it very restrictive. I have to ask someone to go with me. I don't ask very often because they're busy". We asked relatives a similar question with regard to staffing levels. One relative said, "There's not enough staff. There's a lot of agency staff. I think it's hard for the residents being washed by people they don't know. I think there should be more male staff, but he's not been asked. Saturdays are worse. At the weekends, the kitchen isn't fully staffed and it means sometimes they don't get their afternoon cup of tea. They put him to bed too early, sometimes at 3.00 or 3.30pm. Sometimes he says 'no' and then he doesn't go. That's what happens when I'm here. It suits them better to get them in bed". Another relative told us, "I think there are enough staff, but she has to wait sometimes when she wants to go to the loo. Today she was still in her room at 11.45am. She said she'd just had breakfast. They were late getting her up".

Staff we spoke with were generally happy with the number of staff, however, they identified that at busy times of the day, for example, when people wanted to get up, it could be difficult. Staff also commented on the number of agency staff that worked at the home. One staff member said they felt things would improve once more permanent staff were recruited. They explained, "They lost a lot of staff when Summerlea sold up. Overall I find it's getting there. I'd like to see more permanent staff because I'm not always happy with agency". Another staff member told us, "In the mornings, there's too much pressure. A lot of residents want to get up early, so an extra pair of hands would be great". On the first day of our inspection, we observed that the majority of people were either still in bed or sat in their rooms in their nightwear at 11am. In addition, one of the registered nurses commenced administering medicines to people at 8.30am, but it was 11.15am by the time they had finished. This did not impact on the administration of medicines, such as analgesia, which required a four hourly interval between administrations. However, little time had elapsed between the morning medicines being administered and the start of the lunch-time medicines administration process. On the second day of our inspection, we observed that staff were not available to assist people to eat their lunchtime meal. Many people had difficulty cutting up their food and resorted to picking it up in their hands to eat it as no help was forthcoming. Some weekends, care staff carried out activities organised and planned by the activity coordinator as the activity coordinator did not always work at weekends.

We discussed staffing levels with the registered manager and with an operations manager. After the inspection, we were told that staffing levels were constantly under review and that the last dependency score evidenced additional staffing provided over 600 hours a week. However, we found that staff were not always deployed efficiently around the home to ensure people received the support they required promptly.

The above evidence shows that staff were not always deployed effectively. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recording of accidents and incidents; these were satisfactory. Details of any accidents, incidents or 'near misses' were recorded, together with the outcomes. We looked at audits relating to the maintenance of the home in relation to health and safety. Records had been completed appropriately in relation to water, Legionella testing, gas safety, electrical installations, lift maintenance and fire safety. Equipment was serviced as needed. A programme of replacement of emergency lighting had been completed in response to identifying a pattern of frequent failings. The maintenance man told us that the provision for maintenance and servicing of premises and equipment had greatly improved since the home had changed providers. Fire drills and testing of fire alarms were completed. We were told that fire marshal training was taking place next week.

We asked people whether they felt safe living at the home. One person said, "Yes. The people are nice. It makes such a difference when people are nice. I feel at home". A second person told us, "I'd say I feel safe a high percentage of the time. They are quite laid back here, they don't panic". We asked relatives the same question. One relative said, "Oh yes, she's safe". Another relative told us, "Well I don't think he's exactly in any danger. Sometimes there's not a lot of staff around. You used to see them walking about in the corridor and they'd look in. It made you feel more confident when you saw they were making sure people were okay". However, a third relative commented, "I don't think they know how to look after her. I worry about leaving her when I go home". The registered manager told us that a new call bell system had recently been installed and that staff carried pagers around with them which showed which room/person required help and support. The registered manager felt there had been an improvement in staff response times as a result of the new call bell system.

We asked staff about their understanding of keeping people safe and staff told us they had completed training in adults at risk. One staff member told us about the different types of abuse they might encounter such as financial or physical abuse. They explained they would report any concerns they had to the management and were confident it would be escalated to the appropriate authority. They said, "It's our duty to provide a warm, happy, healthy home, free from abuse or harm and I try to meet people's needs to the best of my ability". Another staff member seemed a little unsure about the concept of safeguarding and told us, "Everything has to be safe for everyone – visitors and staff in the building. There are different types of abuse – physical, being withdrawn, not engaging, that could be a sign. Acting out is another sign of abuse and if you see bruises or anything, first you need to inform the manager and take action rom there".

Safe recruitment practices were in place. Staff files we checked showed that potential new staff had completed application forms, received a job specification, two references had been obtained to confirm their suitability and good character for the job role and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people in a care setting.

We looked at the management of medicines. Three medicines trolleys were operated by three registered nurses who administered medicines. We observed a registered nurse administering medicines and they washed their hands before starting to administer medicines and between each medicine administration. The registered nurse wore a tabard which stated they should not be disturbed. Medicines were administered into separate pots or onto spoons, which were disposable and thrown away after each medicines round. Some people were given fortified drinks to increase their calorie intake. People were asked if they would like pain relief. MAR charts were completed appropriately and staff had signed the MAR to confirm people received their medicines as prescribed. We were told that the week after our inspection, medicines would be changed to an eMAR system which meant that records would be completed electronically. Staff had been trained in the new system and new medication profiles for people would be shared with the pharmacy. Medicines were stored and disposed of safely. Staff competencies to administer

medicines had been completed.

Requires Improvement

Is the service effective?

Our findings

Since a change in legal entity to the new provider, staff did not receive regular supervision meetings and support. One member of staff told us that they had not had a supervision meeting for over a year. Another staff member said they had met with senior staff to discuss their progress with a health and social care qualification, but that this was not a 'proper supervision'. It was acknowledged by management that there were gaps in the supervision records, but we were told that all staff had completed competency assessments and new staff had probation reviews. However, one staff member told us that they had not had a 1:1 supervision as part of their probation, but that the registered manager always asked them how they were feeling. We looked at some competencies which had been completed for nursing staff. Nursing staff had been observed giving injections or providing wound care. We saw a clinical competency assessment for one registered nurse in relation to syringe drivers and this stated, 'You need more practice and supervision'. No opportunity to complete competencies for the syringe driver was available as no-one living at the home required a syringe driver. Training in the use of syringe drivers had been provided to all nurses. Following the inspection, we were told that it was planned that every member of staff would have a supervision or appraisal within the next four weeks. The registered manager said, "We are very behind on supervision and appraisal. Unit seniors will be responsible for supervision and induction on their units".

We looked at a staff survey which had been completed in July 2017 and 11 responses had been received. One-third of staff who answered felt they did not have enough information when starting a new shift about the duties they had to undertake, one-third who answered said they did not receive support or formal supervision from their line manager and one-third who answered did not attend team meetings. Over three-quarters of those who answered did not feel there was a strong feeling of teamwork and co-operation.

The above evidence shows that staff did not receive supervision and appraisal necessary to enable them to carry out their duties. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. Capacity assessments had been completed for some people, but not for others. For one person, their relative had power of attorney to make decisions in relation to their health and welfare. In this instance, it was decided that bed rails should be put in place to prevent the person from falling out of bed. The decision made by the power of attorney had been made in the best interests of the person, but it was not clear how the decision was reached and it was not

formally recorded. An advanced care plan for one person recorded they had a diagnosis of dementia and lacked capacity, but there was no capacity assessment on file to show how this conclusion had been arrived at. A consent form for another person completed on 11 March 2015 stated they had capacity, but the person's capacity had not been reassessed since that time.

It was not clear how people were asked for their consent in relation to their care and treatment as this was not formally recorded in all cases. Nor was it clear how people's particular communication needs would be met, for example, in the use of accessible formats or easy-read. A relative told us, "I think staff have got the skills, but with the dementia she doesn't always understand them. Staff should try her with something if she just says 'no', not just assume she really understands and means it".

The above evidence shows that care and treatment was not always provided with the consent of the relevant person or, where they lacked capacity, in line with the provisions of the MCA. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all staff had completed MCA training but broadly understood the requirements of the Act. One staff member talked about the five principles underpinning the assessment of mental capacity and added, "I assume everyone has the ability to make a decision". Another staff member told us about one person who lived with dementia and stayed at the home. They explained, "We did a best interest assessment for her as she lacks capacity. She doesn't retain information. She will be safe and will be taken care of. The GP has been sent a best interests form. She came with a mental capacity assessment". They went on to tell us about DoLS and said, "It's for residents who will endanger themselves when they leave the building".

A three day induction was run monthly by the provider's trainer for all new staff. This comprised a home-specific induction and training in safeguarding, whistleblowing, equality and diversity, basic life support, fluids and nutrition, safe moving and handling, fire safety, infection prevention and control, dementia awareness and learning disability and health and safety. Records showed that new staff completed this induction programme. All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics, which the provider had introduced. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. New staff were required to complete a minimum of three days' shadowing before being allowed to work more independently. We looked at the training spreadsheet which comprised mandatory training in areas similar to the induction programme, plus mental capacity training. In addition to some face to face training, staff were required to submit workbooks to demonstrate their knowledge and understanding on particular topics.

We asked staff about the training they had completed. One staff member told us about the training they had received and that the training workbooks were effective. Another staff member said, "Head office send a trainer for safeguarding and manual handling. Other training we do in groups with DVDs, then we have to answer questionnaires. It feels very good; there's constant refresher training". Staff were encouraged to undertake additional vocational, work-based qualifications, such as diplomas in health and social care.

Staff meetings took place intermittently and we looked at the staff meeting minutes for 28 September 2017. These showed that several areas had been discussed including, challenges for staff, pay review, call bell system, DoLS, safeguarding and whistleblowing, uniform, communication, mobiles, record keeping, staffing levels and standard of care. We saw nurses' meeting minutes from a meeting held on 12 July 2016 and a domestics' meeting held on 12 April 2017. One member of staff told us they attended regular senior meetings to discuss any changes.

We asked people whether they had sufficient to eat and drink and for their views about the meals on offer. Feedback was mixed. One person said, "The food's good; I can't complain about the food". Another person told us, "The food is not very good, it's not cooked properly. I like my food well done and what you get is not all that. Sometimes I don't bother to eat it. They don't give you anything else". A third person said, "It's okay, but there's not enough of it. You decide what you want for meals the next day. Staff read it out and you choose". A fourth person told us, "The food is poor. The breakfast is okay, but the other meals, I never look forward to them. They mean well. The chef comes up and asks what I thought. I always say 'thank you' to be polite, but I eat to exist, not to enjoy". Relatives also told us about the food on offer. One relative said, "She loves the food and there's a lot of variety. We're very happy with the food, but we had to nag about the drinks. We really nagged about it. I said there's no point in giving her water, she won't drink it, they give her juice now. They keep records of what she drinks now, but that didn't happen at the beginning". A second relative said, "Some of the food is quite good, but I think the portions are too big, but there, he's a healthy, steady weight. There's a lot of pasta. By the time he gets it, it's quite cold. I ask them to reheat it when I'm here". People did have sufficient to eat and drink, but feedback about the quality of the food was not positive overall.

We observed the lunchtime meal in the main dining room where 13 people were sat down. People were given soup which was served for them at the table. People were asked if they wanted soup, but were not told what sort of soup it was. The next course was fish and chips. Several people had difficulty in eating the meal, either because they were unable to use a knife and fork simultaneously and had to put down one in order to use the other; other people were unable to use the knife effectively to cut the fish. This seemed to go unnoticed by staff. Some people ate with their hands and others ate very slowly, which meant the food would have been cold by the time they had finished eating. Two people were assisted to eat. One staff member told the person they were assisting what the meal was and what they were putting on the fork, as the person's eyesight was poor. The staff member asked if the person was enjoying the meal, to which they replied, "Not really". The staff member did not respond to this and continued with the task. Another member of staff began to assist another person, but the staff member was not attentive to the person's needs. They were replaced by a second staff member who was more attentive and made conversation with people. We observed that staff did not engage people in conversation, although we saw one staff member who had chosen to eat with people and was conversing with them. Where staff were assisting people with their meals, we observed that the majority of interactions were mainly task focused and there was little social engagement or conversation. We provided feedback to the provider about this at the end of our inspection.

Menus were planned over a three week cycle and offered a variety of choices to people, including meat or fish and vegetarian options. The main meal of the day was served at lunchtime, with a lighter meal at supper. Special diets were catered for such as gluten-free, dairy-free, no fish, pureed diets and food suitable for people living with diabetes. Drinks were freely available to people and we saw that people had drinks to hand in their rooms. However, we observed that many people had two or more mugs placed on their bedside tables. We saw that care staff delivered fresh drinks to people throughout the day, but did not always clear away unwanted or empty cups. This could be confusing for some people. For example, they might not have known which drink was fresh and which drink might have gone cold because it had been left there. People received sufficient to eat and drink and were encouraged in a healthy diet. There was a lack of social interaction between people and staff during the lunchtime meals we observed. We discussed these issues with the provider at the end of our inspection.

Care plans we looked at showed that people had access to healthcare professionals and services. The registered manager said they always tried asking for GPs to visit when people became unwell but that paramedic practitioners were often sent instead. There were some issues as to whether people received

effective healthcare support as needed and the registered manager said they were looking to arrange for a GP to be retained to make regular weekly visits. The registered manager told us people had access to a podiatrist and a physiotherapist at six weekly intervals. Care plans showed that people received healthcare support as needed from district nurses, opticians, audiologists and dentists. People and their relatives told us that they received the support they needed in relation to their healthcare. One person was concerned because they had sustained a head injury after a fall and their sutures had not been removed. However, we later found out that these sutures were self-dissolving and the wound had healed satisfactorily. Staff had not told the person that their sutures would not need to be removed.

The home did not utilise signage or contrasting colours fully to enable people living with dementia to navigate their way around the home. One person told us, "I get a bit tired of the corridors. They put me off and I think I'd get lost". We asked another person what they were doing outside one bedroom door. They said they thought this was their room, but a member of staff told them it was not their room which was located on the other side of the home. People's bedroom doors were not always personalised to make them more recognisable. We recommend that the provider looks at ways to improve the environment to make it more dementia friendly. Following the inspection, the provider informed us that work had already commenced before inspection to improve the environment, for example, the re-numbering of rooms and replacement of some bedrooms doors.

Requires Improvement

Is the service caring?

Our findings

In the main, positive, caring relationships had been developed between people and staff. We asked people whether they thought staff were caring. One person told us that most staff were "all right" but was not complimentary about the approach of two staff members. Another person told us, "Overall they are. How nice they are seems to be in relation to their degree of seniority, but I get on well with them all. The handyman is excellent. He's always cheerful and happy to do what he can for you". A third person said, "They're a bit bullying sometimes, not in a nasty way, but they're demanding. If you've grown up with a mind of your own and they put pressure on you, you think, 'Can't you put that another way, so it's more of a suggestion?'" Relatives told us they were always made to feel welcome. A relative referred to the caring nature of staff and said, "Some are very caring, although all the very good ones have left. Some of the permanent staff are very good. I wouldn't say 'excellent' because none of them are prepared to go the extra mile". Another relative said, "The staff are friendly and capable". A third relative said, "I heard a woman crying out. She was sitting on the edge of the bed and it looked like she would fall off. I said to one of the staff, "Can't you see to her, she's going to fall of the bed?". He said, "No, I'm just going, my shift is over". I just lost it. I thought – that could have been my relative". We later found out that the staff member in question had been spoken with to ensure a similar situation did not reoccur.

We asked staff about their understanding of delivering person-centred care. One staff member gave an example of a person who liked to complete crosswords, but always in the toilet, so that was provided for. The staff member said, "It's not for us to say where they should do their crossword!" We observed many occasions of warm, friendly interactions between people and staff. For example, on the second day of our inspection, a new person was being admitted to the home. The activities co-ordinator took time to introduce the new resident to other people in the lounge and then chatting to their relative to find out what the person's interests were. One member of staff told us that two people received Holy Communion from a visiting priest and that another person visited Arundel Cathedral every year.

We asked staff how they involved people in decisions relating to their care and how they were supported to express their views. One staff member said, "We give people choices about what to wear and food and drink. We ask questions about everything that's going on around them. With one person, she smiles sometimes and we talk to her, we try to see what she wants and talk to her. We make people feel that they can still make their own decisions".

Staff were asked about how they would treat people with dignity and respect and protect their privacy. One staff member said, "You always give people choice. I knock on their door and refer to them by their preferred name. I respect their privacy, spiritual needs and confidentiality". Another staff member told us, "I always ensure people's wishes are respected, that curtains are drawn and I knock on their door. I say what I'm going to do, explain and get their consent, With personal care, I cover their private parts with a towel".

However, we observed one incident where a person's privacy and dignity was not respected. We observed the person was lying on their bed with their back facing the door and their door had been left open. We saw their trousers were coming down at the back which exposed the top area of their buttocks, the top of their

incontinence pants and the top of the pad. The registered nurse who was busy administering medicines at the time said, "Sorry about that", gave the person their medicines and went to leave the room. We suggested that this person's trousers be pulled up. The registered nurse agreed and rang the call bell to summon a member of care staff, so they could continue with the administration of medicines. After approximately two minutes, a staff member arrived and told the person, "I think you have pressed your bell by accident as you're lying on it" and went to leave the room. We approached the staff member and suggested that the person's trousers could be pulled up. The staff member agreed and shut the door; later we saw that the person's trousers had been pulled up.

Some staff lacked a caring approach when addressing people and did not always take account of people's care needs in a sensitive way. This is an area of practice that needs to improve.

Requires Improvement

Is the service responsive?

Our findings

We asked people whether they were involved in planning their care and in reviewing their care plans. One person said, "I can't remember, probably". Two other people did not think they were involved in going through their care plans. We asked the same question of relatives. One relative, referring to their family member, said, "Before she moved in they went to the house and did an assessment there, but when she moved into the home, it wasn't available. They couldn't find it". Another relative told us, "The care plan should be in the office. I wasn't asked to contribute to it. We did his life story when he first came here. There was a file with his photo on the front; I don't know what happened to it". There was no evidence to show how people or their relatives were involved in planning or reviewing their care.

We looked at the assessments which had been completed for people prior to them moving into the home and this information was used as a basis for drawing up care plans. New care plans were in the process of being developed and the registered manager said, "Care plans are a real issue". A member of the nursing staff told us, "I've just started doing care plans. I haven't done care plan training. I feel that I could do with it". Referring to one of the management team, they added, "They are aware, it has been highlighted. The training was meant to happen and it got cancelled". Care plans we looked at were not always complete and were not written-up in a person-centred way. For example, we looked at one care plan, which included a 'grab sheet' should the person need to receive emergency treatment and information about their care and support needs be required urgently. The grab sheet was a summary document. The assessment had been completed and showed details of the person's health and wellbeing, health care, eating and drinking, condition of skin, continence, mental capacity, safe care and support, communication, infections and allergies, mobility, mental health and social support. The assessment had not been signed or dated, so it was difficult to ascertain when it had been completed. There was little information on file in relation to this person's life story or information in relation to significant relationships, places and life events, including wishes for their future care, had not been completed. The care plan lacked detailed information to provide staff with guidance on how to meet this person's care and support needs effectively. In another care plan we looked at, the person had a significant disability, but their care plan gave little information about the nature of this disability or guidance for staff. When we met this person, we saw they had extremely long, discoloured fingernails. When we pointed this out to staff, this person's fingernails were cut, with their consent. Some care plans contained information which had been recorded when the care home had been owned by a different provider. Care plans we looked at had not been reviewed on a regular basis.

We asked staff how they found out about people's care needs, since care plans did not provide all the relevant information. One staff member said, "I understand there are changes happening. Nurses used to do reviews before. I was involved before, but care staff will help to review and write-up care plans. I believe families are involved. I read the plans if I get a chance and to get a basic knowledge of people's conditions and what their needs are. Care plans are disorganised and somebody new can struggle". This staff member, and other staff we spoke with, told us that handover meetings took place between shifts and these provided staff with the opportunity to share information about people verbally. However, one staff member we spoke with said they did not feel this was a, "safe way to work". We were given a copy of the handover sheet and this just contained a list of people's names; there was no pre-populated information. For example, details

about people's specific medical conditions, mobility or support needs. A member of staff felt it would be useful to include such information, especially for agency staff who would not know people. The staff member explained, "The handover sheet needs more information. It's an issue. If I'm working upstairs, I don't know people".

The above evidence shows that people, and/or those important to them, were not involved in planning their care. People's preferences were not always recorded to ensure they received personalised care. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection, an operations manager stated they had identified shortcomings in relation to record keeping and had already introduced improvements. A new handover sheet had been developed, to include information about people's health conditions and care needs.

Staff we spoke with had a good understanding of person-centred care. One staff member said, "It's based on what the person needs. It's individualised". They talked about two people, their care needs and how they would look after them. This staff member added, "Residents need help to get up in the morning; some like to spend time in bed. It depends on the person. With diabetics, we need to make sure they have a proper diet. We give people protein shakes, it's what the doctor prescribes or suggests".

An activities co-ordinator was employed and we observed activities that had been organised during our inspection. On the first day, a floor game was in progress and people were encouraged to participate, following instructions on what the game entailed. One staff member said, "The activities co-ordinator goes around and talks to residents every day. She tries to involve them in activities". Another staff member explained how people at risk of social isolation had their needs met. They told us, "They have recently employed an activities co-ordinator. Residents are brought to the lounge daily. It's normally busy. Entertainers come regularly … One or two residents go out with their family for trips to the church". Occasionally outings were organised for people into the community on a minibus trip. People who stayed in their rooms had 1:1 time with the activities co-ordinator.

We observed the activities co-ordinator was warm and chatty with people and encouraged people to converse and take part in the activity. One person was asked if they wanted to remain in their wheelchair or sit in an armchair. They elected to stay in their wheelchair and were then assured they could change their mind at a later stage, if they wished. We saw eight people taking part in a snakes and ladders game played on a large mat. People appeared to enjoy this activity. After the inspection, we were told that every person had a one page social profile which outlined the various activities people had participated in. A hairdresser was visiting on the first day of inspection and we observed that people enjoyed engaging with the hairdresser and having their hair styled.

We looked at the complaints that had been logged in 2017; eight complaints had been received. Complaints were dealt with within 28 days, according to the provider's policy. Some complaints were still in the process of being resolved. We asked people how they would raise a complaint if they had any concerns. One person said, "We've made lots of complaints. I'd speak to the manager or operations manager. I think they were well handled. I complained about a member of staff and she doesn't work with me anymore. I've complained when I've been left waiting for an hour and a half to go to the toilet, things like that, and the staff have been told". We spoke with relatives about raising complaints. One relative said, "I used to go straight to the manager, but this new one, I'm not so sure, she's just getting used to it. She just smiles when I see her; I haven't spoken to her". Another relative told us, "The manager is very obliging. She listens and then she acts". They had issues with a room their family member was living in and the room was changed. The relative added, "They moved her to the room she's got now. It's downstairs, brighter and bigger. I was so

happy". A third relative felt differently and said, "I've complained to the carers and nurses. I've had a meeting with the manager and talked to the social worker and it all still goes on. It's not got any better. They still don't seem to know how to care for her".

Requires Improvement

Is the service well-led?

Our findings

Records relating to the monitoring of the care provided at the home and auditing systems to identify areas for improvement were not always effective. We looked at a care file audit which had been completed in May 2017. This showed that four files had been checked, but it was unclear what the outcomes were as a result of this audit or of any actions that needed to be taken. As part of the audit, a hospital admissions log, devised by the provider, had not been completed properly and information where people had been admitted to hospital, was incomplete. For example, one person had been admitted to hospital with suspected septicaemia, but the information relating to whether they had received appropriate care and monitoring, whether medicines had been prescribed and administered appropriately and their fluid intake monitored, had not been completed. One audit had been completed in relation to nutrition and hydration in February 2017, but not updated since. Care records were not stored in a confidential way and we saw care plans that had either been left on a desk in an upstairs office or in an unlocked cabinet. The room was left unlocked and unattended. We found one person's care notes had been filed in another person's care plan. One staff member said, "Paperwork is a nightmare at the moment. We need the right team to tackle this". A file containing information about people's weights had been left in one person's bedroom, where anyone could have seen personal details about people living at the home.

Another person, who had a graded pressure ulcer, required to be repositioned in bed, at two hourly intervals during the day and four hourly intervals at night, according to their care plan. We looked at a range of daily records for September which had been completed by staff. These showed that this person was not always repositioned at regular intervals as needed. For example, on 4 September, during the night, they were not turned for a period of seven hours. On 5 September during the day, they were not turned for four hours on two occasions and during the night were not turned for nearly seven hours. We shared our concerns about the gaps in record keeping with an operations manager who later informed us that the staff member responsible had 'forgotten' to record the interactions. We were provided with later copies of repositioning charts which showed that the person had been turned at the required intervals.

We looked at a continence care plan for a person who had a catheter in situ. This care plan stated that staff members should ensure the leg bag was emptied and the catheter output must be recorded. This had not been done. An operations manager later told us that this person was fully independent with their catheter care and that the guidance in the care plan was incorrect. They added that this decision had been made with healthcare professionals and that the person needed to manage their catheter care independently in order to return to living in the community.

The above evidence shows that the quality and safety of the service were not always operated effectively. Records relating to risks were not always managed safely and there were gaps in recording information relating to risks within care plans. Records relating to service users were not stored securely. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The monitoring of accidents and incidents were recorded and audits were in place to identify any emerging patterns or trends. A call bell audit sampled a number of rooms and how long staff had taken to respond to

call bells. We saw an audit which had been completed in relation to health and safety and an action that had been taken. Audits in relation to infection prevention and control had been completed appropriately.

People were asked for their views about the service through questionnaires and at residents' meetings. We saw a record of a friends and family meeting which had been held in July 2017. We looked at a residents' questionnaire which had been completed in July/August 10217 and 10 responses had been received. People were asked whether they contributed to the planning of activities and people were 'partly satisfied'. As a result, an activities co-ordinator had been recruited. People were asked if they were happy with the food on offer. Where people expressed dissatisfaction, a food survey had been completed and actions taken. For example, colour coded beakers had been introduced to differentiate between liquids such as tea, soup and squash. Social and healthcare professionals had provided positive feedback in three comments received. We looked at four compliments that had been received recently. One stated, 'We would just like to thank the entire staff at the home for their care in looking after [named person] over the last eight years. You have made her time here as best as it could be'.

Staff gave us their views about the management and leadership of the home. One staff member said, "I can see a lot of potential and it needs a strong manager who will turn things around". They went on to say, "The residents – that's the reason I stay, because I love my residents". Another staff member told us there had been a lot of new staff recruited recently and new changes implemented. They said, "I feel it is all happening to fast, but I like the direction. Agincare seems more supportive [than the last provider]". They added, "I do think the management is approachable and they have a good knowledge". Staff told us that they frequently observed the registered manager chatting with people, their relatives and staff and that they had a visible presence at the home. Staff felt supported by management in their roles. A staff member said, "I feel well supported. There's an open door policy. We can speak to management any time. We can send an email or make a phone call. We had a staff meeting two weeks ago. You can say everything about what's going wrong, any ideas or improvements. You can talk openly and it gets actioned". They added that when it was identified the call bell system was not working properly, a new system had been put in place very quickly. Staff were recognised for their achievements and could be nominated to be 'Employee of the month'.

Relatives were not so complimentary about the management. One relative, when asked if they felt the home was well managed, said, "Not at the moment. They're too busy putting up new numbers on the doors. The everyday care hasn't been kept up". However, one person said, "She's good the manager, but I don't know if there's a keyworker. I like to be able to speak to one person. You get one thing sorted and then you speak to someone else and they don't know anything about it. And the staff change a lot".

Following the inspection, an operations manager sent us information and action plans to address the issues and concerns we found at inspection. Regular updates have been received on progress made, with dates for completion on areas that required improvement. Since the inspection, a new manager and deputy manager have been appointed to the service. The previous registered manager and deputy manager are no longer employed by the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met: Service users were not involved in the assessment of their needs and preferences. Care and treatment was not designed to make sure it met service users' needs. Regulation 9 (1) (2) (3)(a)(b)(c)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met: Consent to treatment was not always obtained from the service user. Where service users were unable to give consent because they lacked capacity, staff did not act in accordance with the 2005 Act. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for service users. Regulation 12 (1) (2)(a)(b)(g)

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	How the regulation was not being met: Systems and processes had not been established or operated effectively to assess and monitor the service. Systems were not effective in monitoring and managing risks. Records relating to the care and treatment of service users were not kept securely. Regulation 17 (1) (2)(a)(b)(c)

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 How the regulation was not being met: Staff were not always deployed in such a way to meet people's care and support needs in a timely fashion. Regulation 18 (1) (2)(a)