Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Amerind Grove Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 28 and 29 July and 10 September 2015 and was unannounced. The visit that took place on 10 September 2015 was in relation to specific information received regarding safeguarding concerns and the welfare of some people living with dementia.

The last full inspection took place in February 2015 and, at that time, six breaches of the Health and Social Care (Regulated Activities) Regulations 2014 were found in relation to staffing, respecting and involving people who use services, meeting nutritional needs, assessing the quality of service provision, hygiene and cleanliness and records. These breaches were followed up as part of our inspection.

Amerind Grove is a nursing home with a total of 171 beds. The home is split between five individual units. All units have people resident who are living with dementia.

Summary of findings

Picador unit provides residential care. Kingsway provides nursing care and Capstan, Embassy and Regal providing a mixture of nursing and residential care. At the time of our inspection there were 135 people resident in the home.

The overall rating for this service is 'Requires improvement' however there is a continued rating of 'Inadequate' in the key question of 'Safe' and therefore the service is in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There was no registered manager in place at the time of our inspection; the general manager in charge of the home was a relief home manager who was covering the role whilst awaiting the outcome of recent recruitment for the registered manager position. 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 home was not suitably clean and the hygiene practices of staff did not meet the Department of Health guidance for the prevention and detection of infection.

The provider had failed to report and take prompt action as required regarding safeguarding and adverse incidents appropriately.

Staff had not received regular supervision; the provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views.

People who presented with behaviour that challenged were not protected from inappropriate restraint because staff received insufficient training in this area.

Records used to monitor people's health and record best interests decision making were not always completed.

Training in the Mental Capacity Act 2005 had been provided, however staff knowledge about the protection of people's rights was variable The manager was aware of their responsibilities in regard to the Deprivation of Liberty Safeguards ("DoLS"). However not all required applications had been made. (These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty). These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. Not all staff were aware of which people were subject to DoLS, or the conditions attached to them.

We received positive feedback about the care staff and their approach with people using the service; however we observed occasions when people's dignity had been compromised.

The provider had failed to make appropriate notifications; notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

Overall we found that quality and safety monitoring systems were not fully effective in identifying and

Summary of findings

directing the service to act upon risks to people who used the service. Neither had the regulatory breaches identified at the last inspection in February 2015 been remedied.

Staff were not always responsive to people's needs. We saw that, on occasion, staff failed to respond to people's basic care needs, such as ensuring that people were clean after they had dropped food on their clothing.

The administration and storage of people's medicines was in line with best practice and secure. People received their medicines on time and suitable arrangements were in place for the ordering and disposal of medicines.

We had feedback from staff, people and relatives that the current staffing arrangements met the needs of people using the service. This was supported by our observations.

Appropriate recruitment procedures were undertaken.

Care plans and people's risk assessments were complete and reviewed as expected by the provider.

People had access to healthcare professionals when required, and records demonstrated the service had made referrals when there were concerns.

Staff told us that training met their needs, and were generally positive about the support they received.

The provider had a complaints procedure, and people told us they could approach staff if they had concerns.

We found nine breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The home was not suitably clean and people were at risk from poor hygiene practices.

The provider had failed to report and take prompt action in relation to safeguarding and adverse incidents.

The administration and storage of people's medicines was in line with best practice and secure.

There were enough staff to meet people's needs.

The provider undertook appropriate recruitment procedures to ensure only suitable staff were employed at the home.

Is the service effective?

Requires improvement

The service was not effective.

Staff supervision was not up to date.

The provider had failed to ensure that staff received training to make sure any control, restraint or restrictive practices were only used when absolutely necessary.

Records relating to people's care and treatment were not fully completed toprotect people from the risks of unsafe care.

There was varied knowledge and awareness amongst staff of the Mental Capacity Act 2005 and of DoLS. DoLS applications had not been made where necessary, and not all staff were aware of the conditions attached to individual people's DoLS.

Is the service caring?

Requires improvement

The service was not always caring.

We received positive feedback about the care and support that people received. However our observations showed that, at times, people's dignity was compromised.

People were given choices in their daily routines; however feedback about how families had been involved in care planning was inconsistent.

Is the service responsive?

Requires improvement

The service was not always responsive.

Staff were not responsive to people's needs. We saw instances where people's needs were not being met.

Summary of findings

Staff tried to meet people's individual requests and preferences. Attempts were made to gather information about people's backgrounds and interests.

People had the opportunity to participate in activities.

There were systems in place to respond to complaints.

Is the service well-led?

Requires improvement

The service was not always well led.

There was not a registered manager in place.

The provider had failed to make appropriate notifications.

The systems in place for monitoring quality and safety were not sufficient toensure that the risks to people were identified and managed.

Staff felt confident that their views and concerns would be listened to.

Amerind Grove 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 28 and 29 July 2015. A further visit took place on 10 September 2015 in relation to specific information received and focused on the key questions of 'safe' and 'well led' in Capstan unit. The evidence from this visit has been included in this report. This was an unannounced inspection, which meant that staff and the provider did not know we would be visiting. This inspection was carried out by seven inspectors, a specialist advisor in dementia nursing and two Experts-by-Experience, who had experience of services for older people on 28 and 29 July and by two inspectors on 10 September 2015. (An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service).

Prior to the inspection, we viewed all information we held about the service, including information of concern and statutory notifications. Statutory notifications are information about specific important events the service is legally required to send to us.

As part of our inspection, we spoke to 31 people who used the service, 8 visiting friends or family, and approximately 27 members of staff including the relief home manager, senior management, care staff and nurses. We tracked the care and support provided to people and reviewed 15 support plans relating to this. We also looked at records relating to the management of the home, such as the staffing rota, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

We made observations of the care that people received, including a formal SOFI observation of the care provided in Picador unit at lunchtime. (SOFI stands for short observational framework for inspection, and is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Capstan unit was subject to restricted visitors on the 28 and 29 July 2015 due to an outbreak of infection and, on 29 July, Picador unit also was made subject to the same restrictions for the same reason. All of the details relating to infection control were observed by inspectors on the 28 July. We found that the lack of care and knowledge of appropriate standards of cleanliness and infection control and prevention by staff increased the risk to service users; this was intensified given that the home had an outbreak of infection.

We saw all shared bathrooms, showers and toilets in the home and found that, other than in Capstan unit, these were generally clean and well maintained. All toilets contained hand soap and sanitiser, paper towels and pedal operated bins. However, we found a number of concerns in relation to cleanliness and infection control in other areas.

The kitchenettes in each unit had areas which were dirty. This included equipment such as crockery, dishwashers, and areas of clutter which prevented effective cleaning. There were also cracked floor coverings, greasy equipment, dusty wall vents and floors in between cookers and dirty walls in the main kitchen.

In Embassy unit kitchenette we saw a fan covered in a thick layer of dust so that, when in operation, dust would be blown into the kitchen. An open (lidless) plastic bin contained used overalls. The floor area under the sink was dirty, and we also saw that used cleaning sponges had fallen onto the floor. The spout of the water geyser, used for preparing people's hot drinks, was also stained. We saw similar conditions in Regal, Kingsway and Capstan units.

Cleansing fluid piped in to the dishwasher appeared to have leaked, causing staining to the floor. A dust covered earth cable protruded from its housing leading from an electrical fitting on the wall. Large plastic containers of tea bags and sugar had been left open, which could potentially attract flies or ants. There were signs of staining on at least one unused tea bag, indicating it had been exposed to liquid.

We also found that crockery was not being thoroughly cleaned because it was stacked in the dishwasher without using the dishwasher stacking rails; the staff told us this was in order to get more crockery into the dish washer. We saw dishwasher rails on the floor at the side of the dishwasher during its use in Embassy and Capstan unit kitchenettes.

In Embassy unit a kitchen cleaning checklist had been completed to the day prior to our inspection. The unit manager told us they monitored cleaning but had not noted the issues we had raised as a concern. There was also a senior housekeeper for the service; the unit manager was unclear if they checked or monitored kitchen cleanliness in the unit.

In Embassy unit we also saw a member of kitchen staff moving from one unit to another without using any hand gel on entering.

People told us that staff used personal protective equipment, such as gloves and aprons, when carrying out their personal care. We did, however, observe some instances of poorly managed infection prevention and control.

In Embassy unit, whilst talking to a person in their bedroom, we saw that a sink of dirty water was evident after the person had received personal care. In addition to this a dirty used glove had been discarded on their bedside table, and another left by the sink. In Capstan unit we also saw a sink full of dirty water left in another person's bedroom; both instances were reported to staff.

We saw a staff member in Capstan unit cleaning food debris from a used dinner plate with their bare hand and, whilst stopping to deal with a request, the plate was put to one side and the staff member came out of the kitchen. The staff member did not wash their hands nor use any sanitising gel. As they walked through the lounge area, in a friendly gesture they gently touched a resident on the face. Given that the unit had an outbreak of infection, this clearly demonstrated a lack of good hygiene and/or staff compliance in controlling and preventing the spread of infection.

In Picador unit we observed a member of staff picking up a dropped cup from the floor and not returning to wipe up the spillage. The drink soaked into the carpet beside the person who dropped it.

In Capstan unit personal toiletries, portable urinals, a used towel and used paper towels were found in the bathrooms. We also found that two toilets did not have any hand

sanitiser, and that one toilet remained blocked for at least two hours of the day. The sluice rooms in this unit also contained items discarded inappropriately, such as commode lids and a pillowcase, and we found that laundry bags were not properly fastened.

This was a breach of regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes were not operated effectively to take appropriate action immediately upon becoming aware of any allegation or evidence of abuse. Incidents and accidents were recorded and cross referenced to the care files of people involved in the incidents. A monthly submission was made to the main office where results were collated for the whole service. Accidents and incidents were separated into injury and non-injury and had been reviewed by the unit manager following the incident. We saw that the review was to include treatment given, witnesses and any remedial action taken and included body mapping of injuries, marks or bruises. We found that in some incident forms the management investigation summary of the incident was blank. There were also delays in sending the relevant detailed information to the Commission and the local authority safeguarding team.

At the beginning of August 2015 an agency member of staff raised concerns and the provider did not notify the Commission or the local safeguarding team of this. On 10 August 2015 the mistake was rectified by a member of the senior management team, who ensured that the safeguarding referral was made to the appropriate authorities. The initial information submitted did not cover the extent of the allegations. Full information was submitted on 10 August 2015.

We also found that in Kingsway unit one person had body maps recorded in their file showing a number of bruises. Some of these did not record how these bruises had occurred, and they remained unexplained. From the body maps and other documentation, it wasn't clear that it had been established how the bruises had occurred or whether safeguarding alerts to the local authority had been considered. It did record clearly in the person's file that they bruised easily and care with moving and handling was required; however potentially a safeguarding issue could be missed. These issues were discussed with the unit team leader, who agreed the need for clear records.

This was a breach of regulation 13 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of their responsibilities to safeguard people in their care, and had received training to support them in their duties. Staff were aware of types and signs of possible abuse and their responsibility to report any concerns to senior staff or the manager. Staff also understood the term whistleblowing. Not all could talk about the agencies they could contact if necessary, although they were aware where they could find this information if required. A staff member told us, if they had a concern, they "would report to the nurse initially" and to the service manager if necessary .A member of staff gave an example of how they had reported bruising on a person, and told us that this had been responded to appropriately.

During this inspection we also looked at the arrangements for storing and giving medicines and spoke to staff on each unit. We looked at people's medicines administration records on all of the units. We found that suitable systems were in place for the safe handling of medicines, but some improvements were needed to make sure these systems were always followed.

Most people's medicines were looked after and given by staff. We saw one person was able to manage their own inhalers to help their breathing. A risk assessment was in place to check they were able to do this safely. We saw some people receiving their morning medicines on Kingsway unit and teatime medicines on Capstan unit. Staff explained how people liked to be given their medicines.

A small number of people had plans in place for them to receive their medicines covertly. This means that medicines could be disguised in food or drink to make sure they were taken. Suitable safeguards were in place for this including mental capacity assessments, agreement with the person's doctor and checking with the pharmacy that it was safe to give medicines in this way. Staff explained how they would give people their medicines. However we saw plans for covert administration were not always reviewed regularly to make sure they were still relevant and included the correct medicines. Staff had confirmed they asked their pharmacist for advice on this method of administration but, in most cases, the advice given had not been recorded. This increased the risk the medicines would not be given in the best way.

Inadequate

Is the service safe?

Suitable arrangements were in place for obtaining medicines. At the time of our inspection people's medicines were available for them. Staff told us they did have some problems with delays in the supply of medicines, and had met their pharmacist to try and improve this.

The pharmacy provided printed medicines administration records for staff to complete when they had given people their medicines. We looked at the records in each area of the home. These had been completed appropriately and showed people had been given their medicines as prescribed. Some people had been prescribed medicines, such as pain relief, which were to be given 'when required'. Additional information was available for staff to help ensure that people were given these medicines correctly. Although we saw three examples where these records were not in place.

People confirmed their medicines were given regularly at set times by the nurse on duty who checked that they had been taken. One person told us "I get my tablets from the nurse who makes sure they have gone before they leave me".

Staffing levels in the home were safe. We checked the planned rota for the day and staffing levels matched what had been planned. A staffing coordinator had been employed to ensure that sickness and uncovered shifts were covered so that planned staffing levels were maintained. Agency nurses were used at night and a block contract meant there was continuity in who worked at the home. Staff told us the staffing levels had improved in the last six months and said there were sufficient staff to meet people's needs. Staff told us that they were able to give residents more time and better care. The home manager explained that some of the units were overstaffed and that the staff numbers would not necessarily change if further admissions were made. It was not possible to ascertain if these numbers would still be sufficient when the home was at full residency. People also told us they felt there were enough staff, and we saw that people were never left unattended in communal areas.

People told us they felt safe in the home. There were lots of positive comments made including; "I am safe without a doubt, staff know what they are doing and how to manage everything; I have no concerns about how I am being cared for and would be able to tell any of the staff if I had". Other people said "It's lovely here. They look after me" and "They keep me safe. All my doors (into the garden) are locked up and I have keys if I want to go out. They always go around at night checking up on you, you cannot fault them". A visitor commented "My loved one has been here for two years and I think they are safe enough, there is always someone with them when they are moving from one place to another. Staff ordered a Zimmer and a wheelchair for them when it became necessary".

Appropriate checks were undertaken before staff began work, and there were effective recruitment and selection processes in place. New staff were subject to suitable recruitment procedures; staff recruitment records were up to date. All of the required pre-employment checks had been completed and recorded. The records showed that the majority of recently recruited staff also had previous experience of working in care.

Requires improvement

Is the service effective?

Our findings

Staff told us they received supervision every few weeks, and felt able to approach senior staff if necessary. We found, however, that supervision had been irregular; the supervision records we looked at supported this. (Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff). We looked at five staff files; the first staff member had received 2 supervisions within the last three months. The second and third members of staff had received two supervisions in 2015; one personal and one group supervision. The fourth staff member had received one group supervision in 2015 so, effectively, that member of staff had not received personal supervision for at least seven months. The fifth staff member had not received any supervision since their employment in April 2015. The relief home manager told us that the provider expected staff to receive six supervisions a year, and that some supervisions had been delayed since the change in management. This meant that the provider had not ensured that staff performance and progress was monitored effectively, and that staff had an opportunity to voice their individual views.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit to Capstan unit on 10 September 2015 we found that to support a person's needs, risk assessment documentation was contained in each person's care plan. These included assessments for their specific needs, such as personal safety and mobility, and mental state and cognition. Assessments were reviewed and updated, mostly on a monthly or three monthly basis. Although care plans contained risk assessments, they provided insufficient staff guidance on how to keep the person safe. The care plans that did not consistently provide enough detail to inform staff how they should achieve this. One person was recorded as expressing challenging behaviour. It was said that they could be aggressive towards staff and other people who used the service. The person's plan provided inadequate information or guidance for staff about how to support the person with their behaviour, possible triggers and de-escalation techniques.

During our visit to Capstan unit on 10 September 2015 we found the provider did not ensure that staff received training at a suitable level to make sure any control, restraint or restrictive practices were only used when absolutely necessary, and as a last resort. We found an occasion where restraint had been used by untrained staff and they had acted in direct contravention of the provider's policy.

There were inadequate behavioural monitoring charts in place to record information about a particular behaviour that someone is experiencing. The aim of using a monitoring chart is to assess and better understand what the behaviour is communicating, and incorporate strategies on how best to deal with behaviour that is challenging to the person and/or others. A person had sustained an injury on 24 August 2015, and the daily notes recorded that the person had bruises on both wrists. On one occasion the person was restrained by staff members due to their behaviour. The provider's policy states that restraint must never be used unless a care plan has been agreed, and staff have been trained to carry out restraint. Staff were not trained on the use of restraint. This placed both the person and staff at risk of harm. Staff told us that they had not received training for supporting people with challenging behaviours and were not aware of any staff guidance held in the care plan or strategies for caring for this particular person. Staff members we spoke to told us that their techniques had developed through their practical experience, rather than through formal training and planned guidance on the person's specific needs. One member of staff told us; "I feel like I've been let down. Apart from basic dementia training I have received no challenging behaviour training. I have learnt on the job and picked up tactics."

Senior staff members told us that their care plans are in the process of being changed and were a 'work in progress.' They acknowledged that staff were not equipped to deal with challenging behaviour and training had been organised. Owing to staff members not receiving the appropriate training, staff and people's safety was not adequately protected in the dementia unit. Owing to their challenging behaviour senior staff members are currently reviewing whether some people are suitably placed in the dementia unit and they "could be looking at three or four people needing to move out".

This was a breach of regulation 13(4)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had variable knowledge of the Mental Capacity Act 2015 (MCA) and supporting people with making decisions.

Requires improvement

Is the service effective?

The MCA is a legal framework to protect people's rights if they lack the mental capacity to make certain decisions. Records of best interests decision meetings were not always recorded for matters such as the use of bedrails. In Kingsway unit we saw that, in one file, bed rail consent had been signed only by the assessor and not by the person concerned. There was evidence elsewhere in the file that the individual had limited capacity. There was no evidence of a best interests decision. This was highlighted with the team leader, who said that new documentation had been introduced, which required the completion of sections relating to best interest decision meetings before proceeding. Other best interests decision records showed appropriate parties had attended the meetings, such as the person themselves, the persons GP, their social worker and family members. Recording errors were noted on paperwork in important areas. For example, in Picador unit, the tick box asking if the person had been assessed was not complete, nor was the box that required completing to show who had completed the capacity assessment.

Many of the people using the service were having their food and fluid intake and weight recorded. This was to ensure they received enough to eat and drink and to monitor their risk of malnutrition. These people had an eating and drinking assessment within their files. Food and fluid charts were in place, and clear recordings were made about the amounts that people had eaten and drunk. Running totals of fluids were kept so that this could be monitored. However we saw that, in Kingsway unit, the space for the nurse on duty to sign that they had seen the forms was frequently not signed. We spoke to the nurse, who reported that it was often difficult to look at all the forms when they left their shift, as the paperwork was in use by other staff. The nurse suggested that this duty could be shared with a senior carer. In Picador unit, when reviewing the weekly weight charts, a total of four minor recording errors by staff between May and the date of the inspection were also highlighted to the unit manager. Without correct recording and action people are at risk of not receiving sufficient nutrition and fluids for their needs.

We found some good practice in relation to the care of pressure ulcers. Documents and photographs were in place to monitor their progress and evaluate them. Repositioning charts were in place where necessary. In Regal unit, however, wound care dressings for one person were not being recorded as per the care plan. The staff were able to establish that this was due to poor recording rather than the dressings not being changed. In Embassy unit we also observed in a care plan that redness to several areas of a person's skin was recorded in the daily notes of care. However, the body map included in the person's care plan was blank.

This was a breach of regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were many people subject to DoLS at the time of the inspection. Additional applications were with the local authority awaiting assessments or authorisation. DoLS knowledge amongst staff was mixed across the units, and some staff could not recall if they had received DoLS training. We spoke to staff in Picador unit; they were unable to tell us which people in Picador unit were subject to DoLS. One staff member told us, "I don't know off the top of my head, I would have to go to their file to find out." It was also evident the staff within Picador unit were not fully aware of the conditions placed on the DoLS authorisation of one person in their unit. This meant there was a risk of the person's rights being breached.

In Kingsway unit and Embassy units there were three people in each unit subject to DoLS; the DoLS records were held centrally, which meant that staff were unable to access them in order to understand how DoLS applied to the people within the unit. These instances meant there was a risk that people's rights would not always be upheld.

In Regal unit DoLS applications had been made for people for whom an urgent application was required, due to their behaviour. In Capstan unit we were told that no one was on DoLS by the unit manager. We found that, across the home, applications had not been made for all people who were deprived of their liberty and lacked capacity to agree to this. We spoke to the relief home manager about this, and were told that, across all units, DoLS applications were being made where necessary. However, due to the high number required and the local authority's delay with processing, not all applications had yet been made, and those that had been assessed as high priority were being made first.

This was a breach of regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where necessary, people were referred to other health care professionals. We saw an example of this for one person,

for whom there were concerns about their weight and nutrition. It was evident that this person had received support from relevant healthcare professionals, as they had been prescribed nutritional supplements. This person had also been seen by the GP that morning, and it was recorded that staff had discussed their concerns about their weight.

We also met a GP who was visiting. The GP reported that, in Regal unit, the manager and nurses worked well as a team, and their instructions were generally being well followed. The GP's surgery audit showed that there were few inappropriate referrals to GP, and that the staff in the unit were proactive in making decisions about end of life care.

We also spoke to a visiting health professional, who told us that each unit was very different, and some were quicker to refer to their service than others. They also said they had noticed a change in the last six months, in that the service had learnt from incidents.

During meal times we saw that there were a range of preferences and choices made by people in each unit. Meals were chosen by residents the previous day, and there was a picture menu available to assist with their choice. Some people wished to remain in their rooms for lunch, some elected to sit in the lounge chairs with a table, and others chose to sit at the dining table. Staff managed the lunch period efficiently. Some people ate independently, some required full assistance and we observed people being supported by their relatives who were visiting. People had different hot and cold meals and choices of drinks. Where people had changed their mind from wanting the meal on the menu they could ask for an alternative; we saw one resident eating fish and chips, which they had requested, instead of the meal being offered and another eating' finger food'. Other people were provided with sandwiches as an alternative. Staff who assisted people gave encouragement, and the process did not appear in anyway rushed. Staff encouraged people to eat, but accepted when they refused to do so.

A visitor told us they thought the standard of the meals was excellent, and that there were ample supplies of drinks and snacks available. One resident said:

"I enjoy the food on the whole, it is not what I was used to at home, I am no longer able to eat without help but it doesn't bother me". Another person said "I get given a choice but I like everything"

People in their rooms had a selection of hot and cold drinks throughout the day and people were observed being offered drinks continuously. One person, when asked if they had enough to eat and drink, joked, "Plenty – I'm surprised my clothes all still fit me."

Training records showed that staff had completed a variety of training courses relevant to their role, such as manual handling, food hygiene, infection control, DoLS, MCA and safeguarding adults. Training records demonstrated that staff had received appropriate induction training. However there had been some delays in ensuring that regular refresher training had been undertaken, as required by the provider. Staff spoke about the training positively. A nurse told us that the provider encouraged regular training and staff to maintain their own professional development. A member of care staff told us about their two week induction, and recent courses they had attended. They had also shadowed a senior care worker, and were supported by senior staff, who told them they could have their induction extended if they didn't feel confident or competent.

People made mixed comments about the staff's skills and knowledge. One person said she felt the carers had the skills required to support her, and that staff explained and involved her in decision making. Other comments included "I have diabetes and the staff know me that well that they do everything for me without thinking". However other comments included; "Most staff are alright but some need to change their ways, basically they are so used to doing things they just tell you as they are doing it. They tell you where you are going and say the doctor will see you". "They do tell me what they are doing when they move me in the hoist, they banged me once with the hoist a long time ago, but it doesn't happen now."

We spoke to another person who told us that, on the morning of the inspection, she was told that she had an appointment for an x-ray at hospital the following day, and she knew nothing about it. The person had asked one of the staff to chase up the Health Centre to see when the appointment was three weeks previously, and she had not been told of it until that day. She said "It was only this morning that the staff looked in the diary and saw that the appointment was for 2pm tomorrow and I hadn't been told. It has been a rush to get prepared for it and to find taxis and carers to come with me.

Requires improvement

Is the service caring?

Our findings

People in every unit other than Capstan unit were able to tell us whether the staff were caring; people said "I think the staff are great", "the staff are wonderful" and that they "could not fault the carers at all, they are kind and respectful".

However, people's dignity and respect were not always protected. We observed several examples of people's dignity being compromised. In Capstan unit two people living with dementia did not have a call bell or a drink within reach, and we found that one of those people was lying on top of their bed and required personal care; the inspector alerted the staff to this. In the same unit we also observed two people who had food debris around their mouth and on their fingers, and were wearing obviously soiled clothing all day from 10am.

In Kingsway unit we observed four people who had been sitting in their wheelchairs at the dining table being moved away by a member of staff, who then 'placed' the residents feet onto the footplates without asking the person, or telling them what they were about to do.

In another unit one relative told us that, when they had arrived to visit, they found their loved one to be lying on their bed 'soaked through' in soiled clothing, and commented this was not unusual, adding they have often noticed the bottom sheet on their bed has several dried-on stains. We also observed some people in the home had long fingernails, which appeared unclean

One person also said "When I am hanging in the hoist and the staff hand me my medication, that is not terribly dignified, but you must not expect miracles."

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

We received mixed feedback from relatives about whether they had been included or involved in care planning. Some relatives told us that they had not been consulted by staff on their views and opinions, while other relatives confirmed that they had been involved in decision making. We found that the level of involvement of relative and other representatives was inconsistent. This meant that where people were unable to express their opinions about the care they wanted, there was a risk that important information about their care would be overlooked.

One relative said they had not been involved with care plans or decision making, despite having joint power of attorney. Another visitor told us they had not seen or been involved in any care plan or review. Other comments made included "No, we don't have care reviews, but I am here all the time." One visitor said they had been involved in, and were consulted on all aspects of their loved one's care, adding there was very good communication between them.

We observed staff being kind and caring in their approach. Staff paid attention to people, a large number of whom were in the lounges. Interactions were pleasant for example, one person was completing a colouring activity and several staff stopped to take interest in what they doing. In Regal unit we observed staff complimenting a person on their hairstyle, and another member who had taken someone out gardening complimenting them on their gardening knowledge.

We completed observations over the lunch period which were positive, other than in Kingsway unit; we saw one person was receiving one to one care from an agency care worker. The care worker was seen sitting adjacent to the person and supporting them with their meal while not engaging in any way, other than to spoon mouthfuls of food into the person's mouth.

Staff were knowledgeable about people's care needs. When we spoke with staff they were knowledgeable about people's preferences and routines they preferred. For example, one staff member talked about how they responded to people who had difficulties with verbal communication.

People's privacy was maintained. All communication was polite, and we observed that, where people preferred, their door was closed. Some people in the service had a key to their bedroom to help them maintain independence, in accordance with their wishes. People were observed locking their rooms before going to communal areas.

In Picador unit we observed in communal bathrooms there were signs to go on the door that read, 'Personal care is taking place.' We also observed that, in Kingsway unit, signs were on people's doors advising that personal care was taking place, and so people should not enter. In Embassy unit we also observed staff knocking on bedroom doors before entering rooms, and ensuring that doors were

Requires improvement

Is the service caring?

closed when personal care was given. This was intended to protect people's privacy. One person in Picador unit said "They respect us when we are having a shower, they are all the same; I do not mind them; they are nice girls to talk to."

Staff were attentive in their approach when supporting people. We observed a member of staff asking a person if they would like to have a shower. The person became agitated and was verbally abusive; the staff member quietly stood aside until the person became settled, then asked the person if they would like to have a cup of tea first, and asked if they should come back in five minutes. We later saw the person walking off with the staff member and returning after having had their shower.

In Picador unit we observed a carer comforting a person who appeared very upset, the carer was speaking very gently to the resident and managed to calm her.

Requires improvement

Is the service responsive?

Our findings

In nearly all units we saw that people that had limited mobility had call bells placed close to hand and, when used, they were answered promptly. People also had their mobility equipment near them to enable them to be independent. Staff told us that people who were not able to use their call bells were also checked regularly. We saw, however, that in Capstan unit one person's call bell was out of reach. When we spoke to a member of staff about this, they explained that the person had no concept of when or how to use the bell. The bell was left out of reach to prevent them from getting entangled with the cable. We looked in the person's care plan and found there was no specific care plan assessment that provided any guidance for staff as to how often they should be checking on the person.

In Capstan unit we also saw a person develop breathing problems after walking; it was a little while before a nurse was able to provide a Ventolin inhaler for the person. Ventolin is a prescription inhaled medicine for people with breathing difficulties. The person was given one dose; we observed however that most of that dose came back out through the sides of the person's mouth. We saw no improvement in the person's breathing as a result of them having received the Ventolin medication.

In Capstan unit we saw one person having some difficulty with their cutlery whilst eating their lunch. They resorted to eating with their fingers, leading to a mess on their face and clothing. Staff were busy with either serving meals or assisting more dependant people to eat, and did not assist the person with their meal. In the afternoon, after lunch had been cleared away, the staff were free to interact with people, and we observed that staff took time to sit and talk with them and the person responded well to them. The staff did not, however, attempt to assist them with the dried food debris on their face and clothes, or their hair, which was also in disarray. By the time we left Capstan unit at 4.15pm the person had still not been assisted with their face, clothes or hair.

We saw that people had been involved in their care planning; wherever possible people had signed their care plans and given consent to their care. We found that pre-admission assessments were undertaken to gather information about a person's individual needs. These assessments were a pro forma document which covered a number of areas, such as mobility, activities and continence. Care plans were then developed from the original assessment.

Care plans appeared personalised and contained unique individual information and references to people's likes and dislikes. One area within the records was entitled 'My day, my life, my history' and contained personalised information about people, such as when and where they were born, where they went to school, their childhood memories and their career. It showed what their preferred hobbies were, their family tree and where they lived, if they had pets and who their close friends were.

When people were asked about their care plans and reviews the majority of people could not recollect having those discussions with staff; one person said "I cannot recollect people having that discussion with me, no-one has asked me." People did however add that staff cared for them in the way they wished.

People's friends and relatives frequently visited. Visitors were welcome at any time, and were able to join in any activities that took place. People responded positively to activities. Daily activities and trips out were available for people to participate in. The site had dedicated activities and staff and people were observed engaged in activities throughout the day. There were notice boards in the entrance foyer of each unit which showed the activities for that week. We saw that coffee mornings, garden clubs, pamper days, singers' and one to one time was part of the activity programme. Staff we spoke to told us that often activities would be undertaken with the people from other units.

There was an activity coordinator working during the inspection. We observed a singing activity taking place, where people had to fill in the missing lyrics of songs they were familiar with. People were clearly enjoying this and participating enthusiastically with smiles and laughter. Staff were smiling and laughing affectionately with people. Not everyone was involved in this activity, but other people who were sitting in the lounge received attention from care staff, even if just a brief interaction as staff walked through.

There were activity logs recorded in people's support files. For one person, it was recorded that 'they preferred their own company' and stayed in their room, but the activity log showed that staff regularly went in to chat. In Regal unit we

Requires improvement

Is the service responsive?

did note that activities recorded on 'Activity and Interaction' forms were limited, and there were sometimes only one a week. We were unable to tell if activities were limited for people in Regal unit, or if this was due to poor recording.

In Picador unit we observed people enjoying one to one time with staff during the day of the inspection. Staff had sufficient time to sit individually with people during the day. On the tables of the dining area we found there were jigsaws, dominoes and 'memory cards' that people engaged in through the day. Some people were keen to show us the garden and the plants, herbs and vegetables they had grown from seeds; one person proudly showed us the first tomato picked that day.

In Capstan unit, one of a group of people sitting at a table became distressed and shouted out. We observed a member of staff was able to distract the person by showing them a photograph album and discussing the people and places in the photos. It was apparent that the care worker knew the resident and their life history well.

People told us that they were given choices in their daily routines, which helped ensure that their views were listened to, and that they were involved in planning their own. We spoke to people about the choices they had around their care. One person said "I feel quite independent. I would feel quite happy asking the staff if I can go out and they let me out. I can lock my door at night time, the staff are happy with that. The staff have got a key to come in".

We also found that people's individual bedrooms were well furnished, and people were encouraged to personalise their rooms with photographs and memorabilia from home. This helped ensure that people's rooms were arranged in accordance with the person's wishes and preferences.

There were systems in place to respond to people's complaints, and we saw that the procedure for making a complaint was on display in the home. We viewed examples of formal complaints that had been addressed by the provider and manager, and saw that the concerns had been responded to. People and relatives confirmed they knew how and where to access the complaints procedure.

Requires improvement

Is the service well-led?

Our findings

The home had been without a registered manager since January 2015. There had been a number of changes of senior and unit management at the home since the registered manager had left. Recruitment for a new 'whole home' manager was being undertaken. During this transitional period the relief home manager was supported by regional managers and unit managers in each of the five units making up the home. The lack of a registered manager meant the provider continued to be in breach of a condition of their registration

Our findings from previous inspections have shown a history of non-compliance with the regulations. This has covered a range of areas, and when improvements had been made, these had not always been sustained.

The provider had introduced additional quality monitoring systems for the service. A provider quality visit, which in the past had been conducted monthly, had been undertaken two to four times a month since the last comprehensive inspection in February 2015, in order to improve upon the previous regulatory breaches. We saw evidence of these visits and some of the actions taken to improve standards. We saw however that some actions being noted for follow up were not subsequently reviewed at the next provider visit. We identified a number of breaches of regulations at our inspection, four of which were continuing breaches from our last inspection. This demonstrated the provider had failed to take sufficient action in response to shortfalls previously identified.

As at other inspections, a number of the shortfalls related to matters which had been brought to the provider's attention on previous occasions. The provider had failed to act on the risks that had been identified. These related to key aspects of the service, such as infection control, the maintenance of accurate records, treating people with respect and dignity and quality assurance.

There were systems in place within each unit to monitor the areas in which there had been a breach of regulations. While there were periodic audits of home cleanliness and infection control, they did not raise the concerns which were prevalent across the home. These systems had failed to ensure that areas in which the breaches of regulations occurred were improved upon.

The failure to achieve good standards also raised questions about the effectiveness of the provider's leadership. The manager told us that they and other senior staff undertook audits in relation to different aspects of the home. There had, however, been difficulty in implementing improvements whilst senior management and unit management staff roles had changed. Continuous improvement had not been sustained effectively.

The provider's quality assurance systems and processes did not ensure that they were able to assess, monitor quality provision and mitigate the risks and relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

This was a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not notify the Commission of all incidents in a timely manner that affected the health, safety and welfare of people who use the service. (Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled). An example of this included where a nurse had made a number of allegations at the end of June 2015 regarding the service, and there was evidence to support the allegations. We were told that there was no evidence to support the allegations. The provider was also made aware of additional information that came to light since the original allegations were made. The provider failed to notify the Commission of this position.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Most of the staff we spoke to told us that they worked well together as a team. We made observations during the day that supported this, with staff communicating effectively about people's needs or different tasks that needed completing, such as taking meals to people's rooms and supporting them. Some staff expressed concern about the inconsistency in leadership across the home. However staff were positive about the relief home manager, and described them as approachable and supportive. Staff all said they would not hesitate to raise any concerns with the current senior management. Staff confirmed they felt able to raise issues or concerns, and felt confident they'd be

Requires improvement

Is the service well-led?

listened to. Staff told us they had opportunities to attend staff meetings where they could raise concerns. One staff member said they felt supported by management "very much so". They said that senior management of the service had been "brilliant" in resolving an issue so that "management and carers were happy". Another staff member said "We work well as a team here in X, X (unit manager) is good to work for."

There were systems to monitor feedback from people and their relatives about the quality of service provision. People's relatives and people who lived in the home were encouraged to complete an annual survey to give their views and feedback of the service. The last survey was completed during May 2015; we saw that people and relatives were asked their views on matters such as their level of satisfaction with staff, the overall service, the environment and the atmosphere. The results of the survey were mixed; there were notably low scores related to activities, visitor facilities and value for money. Areas for improvement had been highlighted as the 'promptness of staff attending' and the 'extent to which BUPA staff listen and respond to their requests'. We saw there had been a relatives meeting in June 2015, with the home manager inviting relatives in to address their concerns. The home manager explained that meetings with people and their relatives were being arranged as a priority, to introduce the management team that were in place whilst recruitment was underway for a registered manager, and to seek their views on how to improve the service. These meetings were being planned to take place at least quarterly, and the management were introducing a 'you said, we did' noticeboard so that people and their relatives could see how progress was being made against issues they had raised.

Messages were communicated to staff through meetings. Different levels of meetings were held at the service. Meetings were held for heads of departments that communicated information from the provider, training matters and staffing. We also saw that some individual unit meetings were held that discussed staffing, training, people's care needs and care plans.

People and relatives made mixed comments about the visibility and access to the leadership of the home and whether they were asked for their views. Visitors' opinions varied on the management structure, they all knew the unit managers, who they saw regularly, but they did not know or have any involvement with the relief home manager. Comments made included "I do not know the manager, there have been so many over the last year, I am not aware of any changes in the past six months, good or bad", "I would not have a clue who the manager is, I have never seen one" and "I have never had to contact the main manager, but have found the unit manager to be open and friendly". One visitor commented that, over the past six months, there has been a notable increase in the number of staff on duty at any time and, in their opinion, the service cannot be improved. One person said "I have never had any feedback forms and I don't know who the manager is and my opinion about the service is never asked." Another person said; "I very rarely see the managers, I would not know them if they walked in the room".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Systems and processes were not operated effectively to take prompt action immediately upon becoming aware of any allegation or evidence of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Staff did not receive adequate supervision**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (4) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The provider had failed to ensure that staff received training to make sure any control, restraint or restrictive practices were only used when absolutely necessary, in line with current national guidance and good practice, and as a last resort.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected against the risks of unsafe care because complete and accurate records were not kept.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 People were not protected because the provider had failed to follow the Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 The provider had failed to make appropriate notifications.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The systems in place for monitoring the service were insufficient to ensure people's safety and wellbeing.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risks associated with cross infection because effective standards of cleanliness were not implemented across the home.

The enforcement action we took:
Warning Notice