Care Quality Commission

The Sisters of the Christian Retreat

Kearsney Manor Nursing Home

Inspection report

Alkham Road
Kearsney
Dover
Kent
CT16 3EQ

Tel: 01304822135
Website: www.kearsneymanor.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was completed on 4 April 2018 and was unannounced.

Kearsney Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Kearsney Manor provides accommodation and nursing care for up to 47 older people who have nursing needs and who may be living with dementia. The bedrooms are located on two floors and accessed by a lift. There are communal rooms on each floor. The gardens are well maintained with scenic views and parking is available. On the day of the inspection there were 44 people living at the service.

There was a registered manager 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.

We last inspected Kearsney Manor on 4 and 5 April 2017, we found ongoing breaches of the regulations and the service was rated 'Requires Improvement' in all domains. There was a lack of sufficient guidance for staff to follow to show how risks were mitigated including when supporting people with behaviour, moving people and managing health conditions. There was a lack of safe and effective systems to ensure that people's medicines were managed as safely as possible. There were not enough staff to meet people's needs. People were not always treated with dignity and respect. Checks and audits were not effective. Feedback from people and staff had not been used to improve the service. We asked the provider to take action and the provider sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. Although the provider had made improvements regarding treating people with respect they The provider had not met all of the previous breaches of regulations and further breaches were found.

When people first moved into the service a '14 Day Care Plan' was completed, which contained basic information regarding how to support people. Staff told us these were updated as and when staff knew more about people, however, we found that they were in place for several months after people had moved in. Although this was completed with people and their loved ones these 14 Day Care Plans lacked essential information to ensure people received the support they needed. For example, one person was living with epilepsy and their care plan contained no information regarding this. They had experienced seizures whilst living at the service, but staff were unable to tell us what the person's seizures may look like or when they should seek further medical advice. The person had been prescribed emergency medicine when they had a seizure, but no one was trained to administer this.

Risks relating to people's care and support were not effectively managed. Some people's skin was damaged and they used pressure relieving equipment. There was a lack of oversight regarding this equipment and we found multiple instances where it was not set correctly, leaving people at risk of their skin breaking down further. Similarly, some people used oxygen, and there was a lack of oversight regarding the cleaning of people's oxygen filters, and this was not consistently happening as required.

Staff did not always recognise and report incidents that had left people at risk of harm. People had become trapped in their bedrails, and although nursing staff had recorded this in their handover document the registered manager had not been informed, and no one had recognised the potential seriousness of these incidents. No action had been taken to reduce the chance of it happening again. The registered manager did not collate and analyse accidents and incidents to look for trends or patterns.

Medicines were not managed safely. When people came to live at the service, they were requested to bring their medicines from home, until the service was able to order medicines from the GP. One person had been given medicine bought in from home, that they were no longer prescribed or needed. Staff had not always followed procedures for medicines with specific storage and administration requirements. Staff had handwritten some people's medication administration records (MARs) and these had not been checked to ensure they were correct. Staff had not taken action when the temperature where medicines were stored was too high. There were no charts to show staff where to apply the creams, how often and sign to record when they had.

We started our inspection early, at 7am as we had received concerns from whistleblowers that there was not enough staff at night. Although we found that there was enough staff to meet people's basic care needs, people told us that during the day they were bored and there was not enough staff to keep them engaged. Staff were kind and cared about people, however they were focused on ensuring people's basic needs were met and as such were task led. There was no activities co-ordinator and therefore a lack of formal activities occurred day to day. Information was not always presented to people in an accessible format.

The provider's vision for the service was to, 'Provide a warm homely and caring environment, where staff feel valued and we acknowledge and embrace the uniqueness of each resident, whose individual physical, emotional and spiritual well-being needs are met.' Although this was the case, people did not always receive person-centred care. Staff used one person's thickening powder for everyone who needed their fluids thickened, even though this was individually prescribed. People were not using incontinence aids designed for their individual needs as they were waiting for continence assessments to be completed.

Only one nurse and the registered manager had been trained to administer a syringe driver, which is used to administer medicine to keep people pain free at the end of their life. There was a risk people may have to wait to receive this medicine if these members of staff were not immediately available.

The provider and registered manager lacked oversight. This was the first nursing home that the registered manager had run. Checks and audits had failed to identify the shortfalls found at this inspection. People, relatives, staff and stakeholders feedback had been sought in January 2018, and although this had been analysed many of the issues we identified, such as a lack of staff to ensure people were engaged had not been rectified, four months on. Staff were not always recruited safely. The registered manager had failed to notify CQC of important events that had happened in the service, as required by law. Complaints were documented and responded to in line with the provider's policy.

The registered manager had sought advice from the local safeguarding and commissioning teams and worked with them closely. They had listened and acted on any advice given, however, this had still not

ensured compliance with the fundamental standards and regulations. Staff had sought advice from a range of healthcare professionals when people's needs had changed, to support people to live healthier lives.

Care staff had received the training they needed to carry out their roles. Staff received regular supervision and an opportunity to reflect on their role. The registered manager had recently introduced a new role to assist people to eat and drink throughout the day. Food appeared home cooked and appetising.

The registered manager had applied for Deprivation of Liberty safeguards when people were unable to consent to living at the service. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Since our last inspection the service had renovated to increase the communal space available for people to enjoy. The building had been adapted to meet people's needs, including a large lift and specialist bathrooms. The service was clean and people were protected from the spread of infection.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks relating to people's care and support were not always assessed or mitigated.

Incidents leaving people at risk were not always reported to the local safeguarding team and were not analysed, to look at ways of reducing the chances of them happening again.

Medicines were not managed safely.

Staff were not recruited safely. People told us they were bored and there was not enough staff to keep them engaged.

The service was clean and people were protected from the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs had been assessed, however when they first moved to the service the assessment lacked important details about people's needs.

Nurses had not received training to ensure they were competent to administer certain medicines.

People had enough to eat and drink.

Staff supported people to make choices and the registered manager had applied for Deprivation of Liberty Safeguards if people were unable to consent to staying at the service.

The environment had been adapted to meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and caring, but busy, meaning care was task-led.

People and their relatives told us they were involved in planning their care.

Staff treated people with respect and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that was personalised to their needs.

People and their relatives told us there were a lack of activities.

Although there were plans in place regarding how to support people at the end of their lives, staff were not trained to administer people's pain relief medicine.

Complaints were documented and responded to in line with the provider's policy.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager and the provider lacked oversight and failed to ensure compliance with the fundamental standards and regulations.

Checks and audits had failed to identify the issues we found at this inspection.

A range of views had been sought regarding how to improve the service, however

CQC had not been notified of important events that happened in the service, as required by law.

The registered manager had regularly sought advice from the local safeguarding team and nurses from the local care home nursing team.

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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 was prompted in part by concerns raised with the Care Quality Commission (CQC) by whistleblowers, regarding staffing levels. We visited the service at 7am to check that there was enough staff available at night.

This inspection took place on 4 April 2018 and was unannounced. Two inspectors and an expert by experience carried out the 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.

The provider completed a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the registered manager, a clinical lead, the head of care, three care staff and two senior carers. We spoke with two visitors and three relatives. We looked at ten people's support plans and the associated risk assessments and guidance. We looked at a range of other records including three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas and quality assurance surveys.

During our inspection we spent time with the people using the service. We spoke with 18 people. We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experiences of care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection we shared our concerns with the local safeguarding and commissioning teams.

Inadequate

Is the service safe?

Our findings

People and their relatives told us they felt safe living at the service. One relative told us, "[My relative] is safe now they are here, and I don't have to constantly worry about the danger of them falling anymore, now they have their call bell with them at all times they feel safer too." One person said, "I feel very content and safe here. I know that I am being well looked after. I have my call bell here should I need help and I am not afraid to use it." And, "My room is all that I need to make me feel safe and I would say I am well catered for." Another person said, "I am safe and sound and most comfortable here thank you." Despite these positive comments, we found people were not always kept safe at the service.

At our last inspection we found that although risks had been assessed guidance for staff regarding how to mitigate these risks were lacking. At this inspection some improvements had been made and there was now detailed guidance for staff regarding how to assist people to move safely and how to support people when they displayed behaviour that challenged. Although the guidance had improved in some areas there was a lack of oversight regarding risk management which left people at risk of harm.

When people first moved into the service a basic '14 Day Care Plan' was put in place, which staff updated as and when they got to know people better. However, risks contained within these basic care plans were not fully assessed and guidance for staff was still lacking. Some people had been at the service for several months and their '14 Day Care Plan' was still in use. One person was living with epilepsy and had experienced two seizures whilst living at the service. Their care plan made no mention of their epilepsy. There was no guidance for staff regarding what the person's seizures may look like or when staff should seek further medical assistance. We spoke with staff and they were unable to tell us about the person's seizures or what action they should take. One staff member said, "I personally haven't witnessed one. I don't know what kind of seizures they [the person] have." There was a risk that the person may not get the support they needed if they experienced a seizure.

Some people were assessed as being at risk of choking and had specialist guidance in place from a speech and language therapist regarding how their food should be prepared. Although we saw people receiving their food and drink as per their guidance there was no information for staff regarding how to assist them, if they began to choke. Staff had received training in first aid, however, when we spoke to them regarding how they would respond if people choked they were unable to tell us accurately the action they would take. One staff member said, "Most people would do abdominal thrusts but I wouldn't pull [the person] up to do it." Another staff member said, "If it is food or a foreign object I would turn [person] on their side. I can't think of anything else. My mind has gone blank." There was a risk that people would not receive the support they needed in an emergency.

Some people's skin was damaged and at risk of breaking down further. They had serious wounds including grade three and grade four pressure areas which meant they had deep wounds which could reach the muscle or bone. People told us they were in pain as a result of their pressure areas. One person said, "My foot is killing me. I cannot put up with the pain today. It is killing me. The pain killers are not helping." People used specialist equipment, such as pressure relieving mattresses to reduce the risk of their skin becoming

damaged further. There was no staff member responsible for the oversight regarding how this equipment was being used. We found that the equipment was being used incorrectly, meaning the equipment was not fully effective, leaving people at risk of their skin breaking down further. We checked six people's pressure relieving mattresses, and five of them were set incorrectly. No one had checked to see if the mattresses were on the correct setting, so there was no way of knowing how long the mattresses had been set incorrectly for.

Some people used oxygen to help them to breathe. This was concentrated through a filter which required cleaning weekly to ensure it was working correctly. Staff did not routinely document in one place when the filter was cleaned. Some dates of cleaning had been recorded on an 'oxygen concentrator filter cleaning chart' and other dates had been recorded in a diary. However, during March the filters were not documented as being cleaned for the weeks beginning 11th or 18th March. We asked staff who had oversight of the cleaning of the filters, how they ensured they were cleaned each week, they told us, "I do not know, but I am sure it is done weekly."

Staff did not always recognise and report incidents which had left people at risk of harm. In March nursing staff had written in their handover document that two people had become trapped in their bedrails. People's skin had become bruised and red as a result. No one had recognised the potential seriousness of these incidents, and the potential injuries that could have occurred. We asked the registered manager what action had been taken as a result of people becoming trapped, and they told us they had, 'not been informed' these incidents had occurred. There were no risk assessments in place regarding the use of bed rails for these people and analysis had not been completed of these incidents to ensure they did not occur again. We asked the registered manager to discuss these incidents with the local safeguarding team, to see if any further action was required.

The registered manager investigated individual incidents when they were made aware of them. However, no analysis was completed of incidents and they were not collated to look for trends or patterns. The registered manager told us they were not, "not aware" they needed to look systematically at incidents and accidents to look at ways of reducing the chance of them occurring again.

At the last two inspections, people had not been protected from the unsafe management of medicines. At this inspection, people remained at risk from unsafe management of medicines.

When people came to live at the service, they were requested to bring their medicines from home, until the service was able to order medicines from the GP. When medicines were brought into the service, staff should check that the person is still prescribed the medicines and record the amount brought in. We reviewed the records of one of the people who had recently been admitted to the service. The person was prescribed Furosemide 40mgs, a diuretic, at 8am. Staff had handwritten the time of 12pm also on their medicine administration record (MAR). Staff told us that they had given the medicine at lunch time but had not yet signed and had added the 12pm dose as a box of Furosemide 20mg tablets had been found that morning and stated that an additional dose should be given. However, they could not tell us when this medicine had been prescribed and by whom. The additional dose of Furosemide 20mgs had been prescribed before the person had been admitted to the service. Staff had not checked with the GP if the medicine was still prescribed. The medicine had been brought to the service on Friday, the inspection was on Wednesday, five tablets had been removed from the box. There was a risk that the person had received medicines that were not prescribed for up to five days.

Some medicines have specific procedures for storage and administration. The medicines require one person to administer the medicine and another to witness. A book has to be signed by both people to confirm the medicine has been given to the person it is prescribed for. Staff had not always signed the book as required.

On five occasions only one person had signed the book.

Some instructions had been hand written onto the MAR chart. It is best practice for the instruction to be signed by two people to confirm it is correct. Hand written instructions had not been consistently double signed to confirm it was correct and to reduce errors.

Some medicines need to be stored at specific temperatures to remain effective. Staff had recorded the temperature of the fridge, medicines room and people's rooms. The temperature of the fridge and some of the rooms on the second floor had been too high. These had been recorded but the action taken and if that action had been successful in lowering the temperature had not been. There was a risk that people would receive medicines that were no longer effective.

Some people were prescribed creams. There were no charts to show staff where to apply the creams, how often and sign to record when they had. There was a risk that people were not receiving creams as prescribed.

The provider and registered manager had failed to ensure that risks were assessed and mitigated where possible. Systems and processes in place did not ensure the safe management of medicines. This was a continued breach of Regulation 12 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Staff were not recruited safely. The provider had a computer system in place to ensure that a person did not start working at the service until all the documents required by regulation were processed. However, this did not check the information provided on the documents. We reviewed three recruitment files where two were new members of staff. The employment history recorded was not detailed and fully completed. The human resources manager stated that they did not know that staff had to supply a complete employment history so had not been checking. Any gaps in people's employment had not been investigated and documented during the interview process.

The provider and registered manager had failed to ensure that safe recruitment processes were in place. This was a breach of Regulation 19 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Disclosure and Barring Service (DBS) criminal records checks had been completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working who use care services. Each person had a proof of identity, references that had been verified and had completed a health questionnaire. Nurses Personal Identification Numbers were checked to ensure they were registered to practice.

Previously, there had not always been sufficient staff on duty to meet people's needs. We visited the service at 7am following concerns raised by whistleblowers that there were not enough staff on shift. However, we found that there had been enough staff overnight. Some people were still asleep and others had been supported to get up and dressed, depending on their preferences.

Following the last inspection, changes had been made to the staffing structure of each shift. There was now a clinical lead who was a nurse, who had clinical oversight of the whole service. They were supported by a senior carer on each floor and carers. A new 'hostess role' had been introduced to support people with eating and drinking throughout the day. Staff rotas confirmed the number of staff available to provide care and support to people had been increased. The provider had introduced an on call system, staff volunteered

to be on call and cover shifts if staff were sick. This had proved to be successful, though; agency staff were still used when cover could not be found.

Although there was enough staff to assist people to get up, throughout the day people told us they were bored, and there was not enough staff to spend time with them or engage in activities. One person told us, "We don't plan anything, and we don't have anything to look forward to, that's what life has become one boring waiting game." Another person said, "I don't do much in the day really I suppose I just wander from my room to the lounge and back again a few times." Staff confirmed that there were a lack of activities and that they were busy, ensuring people's basic care needs were met.

We recommend the provider and registered manager review staffing levels to ensure people are engaged and able to participate in a range of activities.

The registered manager had worked closely with the local safeguarding team since our last inspection, seeking advice and guidance on a range of potential safeguarding matters. Staff were able to tell us about different types of abuse, the signs and symptoms, and what action they would take if they had any concerns. One member of staff said, "I understand the whistleblowing procedure. I would go to my senior or a nurse and then the manager. I could go over their head if needed, to social services or CQC."

Checks had been completed on the environment and equipment used by staff to keep people safe. There were environmental risk assessments in place. Regular checks were completed on the fire alarm system and any shortfalls were rectified immediately. Staff had attended a fire drill, analysis of the drill had been completed and action taken. However, there was no record of the staff that had attended the drill; also there was no schedule to ensure that all staff had the opportunity to practice a fire drill. This was an area for improvement. People had personal emergency evacuation plans in place (PEEPs) to give guidance for staff regarding how to assist them to leave the service in an emergency. There was a contingency plan in place to manage emergencies such as fire or flood.

The provider had a policy on preventing infection and any spread of infection. Staff followed this policy and could tell us about how they would reduce the spread of any infection. There were cleaning schedules that domestic staff followed and this included kitchen staff. The service was clean and hygienic and smelled fresh. There were sufficient domestic staff employed to maintain the standard of cleaning required. Care staff wore protective clothing such as gloves and aprons when required and disposed of soiled linen appropriately to minimise the risk of cross infection.

Requires Improvement

Is the service effective?

Our findings

Staff had not received training to ensure they were competent to administer specific types of medicine. One person was living with epilepsy and had been prescribed buccal midazolam. This is an emergency medicine which needed to be administered in the person's buccal cavity in their mouth, if they experienced a seizure. No one at the service had been trained in how to administer the medicine or shown how it should be administered. There was no guidance in place for staff regarding how the medicine should be administered or when. We asked one nurse how they knew when to administer the medicine and they said, "I have not been trained or signed off as competent. The hospital told me how to administer it and I have told all my colleagues." There was a risk the person may not receive their medicine as prescribed and it would not be effective.

The service was a nursing home, and regularly supported people at the end of their life. Only one nurse and the registered manager had received training in how to administer a syringe driver, which is used to administer a steady flow of injected medicine continuously under the skin. It can be particularly important to ensure people remain pain free at the end of their life. We discussed how staff ensured people were able to receive medicine via a syringe driver if the one trained nurse was not available, and we were told, "The registered manager would come in and sort it." There was no plan in place to ensure nurses were trained to use this essential piece of equipment, and there was a risk people may not be able to receive medicine via this route, as required.

The provider and registered manager had failed to ensure that staff had received training to ensure the safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Care staff received appropriate training for their role. The service had an internal trainer who had completed a qualification in education and training. Training was provided both on line and face to face. External trainers were used when appropriate. Nurses and staff received additional training when their role changed. Senior carers had received training in subjects such as oxygen management, stoma care, suction and diabetes to enable them to be effective in their role. Staff competencies were completed to ensure staff were competent in all areas their role.

New staff completed an induction, including basic mandatory training, shadow shifts with more experienced staff to learn about people's choices and preferences. Staff completed the Care Certificate, the Care Certificate is a set of standards that care staff adhere to throughout their working life.

Staff received regular supervision and appraisal. There was a system in place so that staff knew when they would meet with their supervisor during the year so they were able to plan what they wanted to discuss. Staff were able to discuss their roles and development needs. Nurses received clinical supervision from the registered manager.

People's needs were assessed before they moved into the service. A '14 Day Care Plan' was written,

containing basic information regarding how the person should be supported. We reviewed some people's 14 Day Care Plans and they lacked basic information regarding how people should be supported. For example, in one person's 'medical history' section staff had written, 'notes are available from hospital for full details.' These notes were not readily available for staff, and staff were unable to locate them during the inspection. Without accurate information there was a risk that people may not receive appropriate support to manage their healthcare needs. For example, the person had also been admitted with a 'grade two sacral sore' and there was no information for staff regarding how to manage this or the risk of their skin breaking down further.

When people had been at the service for longer a full assessment of their needs had been carried out, using recognised tools including Waterlow assessments (to assess the risk of people developing pressure areas) and a malnutrition universal screening tool (MUST) had been used to identify people who required more support. Some people were living with healthcare conditions such as diabetes and staff were aware of best practice guidance from the National Institute of Clinical Excellence (NICE) and other sources.

People had been referred to a range of healthcare professionals when their needs had changed. Staff had sought advice and guidance from dieticians if people were losing weight and from speech and language therapists if people were at risk of choking and were following this guidance. The registered manager had introduced a regular yoga session to encourage people to remain active and lead healthier lives.

People were supported to eat and drink safely. People could choose to eat in their rooms or in one of the communal lounges or dining room. The atmosphere at lunch time was relaxed, with staff chatting to people whilst offering them the assistance they needed. Food appeared home cooked and appetising. Some people required food of a soft or pureed consistency, and each element of the meal was presented separately to ensure people were able to taste the different flavours. One person told us, "I always have a nice cup of tea when I ask and lunch is very good too I look forward to that." Another person said, "The food is delicious." Kitchen staff we spoke with were knowledgeable about people's allergies and needs, and provided fortified food when necessary to help people to retain a healthy weight.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager had applied for DoLS for people who lacked the capacity to consent to staying at the service. One application had been authorised, and staff had ensured that conditions on this had been met.

Staff understood the principles of the MCA and people were offered a range of choices throughout the day. One member of staff told us, "Everything is a question, everyone should be offered a choice. It is about knowing a person and how they respond best, but I always ask." When important decisions were made on people's behalf best interest meetings had occurred involving people and healthcare professionals that knew the person well.

Since the last inspection, the provider had undertaken changes to the layout of the building to increase the

communal space available for people to enjoy. The building had been adapted to meet people's needs, including a large lift and specialist bathrooms. The reception area had been developed so that people with mobility needs were able to enter and leave the building easily.

Requires Improvement

Is the service caring?

Our findings

At our last inspection people told us they thought staff were rushed and there was not enough staff. Staff worked to a routine to ensure people received essential care. People had stated they were unable to go to bed and get up when they wanted to.

At this inspection the number of staff had increased, however, people told us although that staff were kind, they were busy and as such did not always have the time to spend with them. One person said, "They [staff] are kind and they occasionally will stop to chat but only if I make a bit of a to do." Another person said, "I would say the staff mean to be kind, but they can just be so busy all the time." A relative told us, "I think [my loved one] does get very lonely if I don't come in, there is no one really to chat to her and she is left on her own."

During the inspection we observed that staff were busy meeting people's basic care needs, and appeared task led as a result. They were kind and considerate, and spoke fondly about the people they were supporting. However, they too told us they would like more time to spend with people one on one. A new role of 'resident support worker' had been introduced to assist people with eating and drinking, and care staff were hopeful this may free them up to be able to do this. However, it was too soon for staff and people to have seen an impact, as this role was still being embedded.

Staff had not ensured that were people were as pain free as possible, as their pressure relieving equipment was not used properly. People told us they were in pain as a result of their pressure areas. Although staff offered them pain relief, they told us that this was not working effectively. The provider and registered manager had failed to ensure that systems and processes were in place to keep people safe and prevented from the risk of avoidable harm. This was not caring.

From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Information about people, such as their care plans were stored electronically and staff were able to access them on hand held tablets with a small screen. This information was not accessible to people living with dementia or who may be confused.

People and their relatives were involved in planning their care. One person said, "The staff always make sure I like the way I am being looked after and cared for." A relative said, "They do try to look after [my loved one] and help them and care for them in a sympathetic way and according to her own wishes." Some people required support to make their needs known, and either an advocate or their relatives helped them to do so. An advocate is someone who supports a person to make sure their views are heard and their rights upheld.

Visitors and relatives were always welcome at the service. One relative told us, "I often call from Australia to check up on [my loved one] and they are so good at filling me in on her condition." Another relative said, "I am always offered tea or coffee when I visit."

Staff respected people's dignity. We observed staff knocking on people's doors and waiting to be invited in. Staff told us they encouraged people to be as independent as possible. One staff member said, "They [people] should all be encouraged to do what they can for themselves."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they were bored, and there was a lack of activities available for people to participate in. Comments included, "There is not much for [my loved one] to do, but at least the view is good." "I do absolutely nothing all day, what is there to do?" "I am bored stiff and that's why I just want to go home." "There is nothing to do and I am just stuck here in this god awful chair." And, "I would like to see a little more stimulation for [my relative] but then I visit almost daily, and we go to their room to talk."

There was no activities co-ordinator employed at the service, meaning that no one had oversight of activities that were on offer. One member of staff told us, "We did have activities, but I do not know where that went." During the inspection people spent time in their rooms watching television and reading. Some people spent time in a small communal lounge, however, there were no formal activities on offer for people to participate in or feel engaged. Some regular scheduled events did occur, such as singers and children from a local school visiting and a regular yoga session, however, days went by without any formal activities occurring.

People and their relatives told us they had been involved in planning their care. One person said, "Yes I have seen my care plan and we do occasionally discuss it." A relative told us, "The staff made sure that they asked me about the way [my loved one] like things to be done and we put a plan in place together." However, although people had care plans in place that had been discussed with people important to them, the information within them was not always accurate or up to date. The '14 Day Care Plan' in place for people when they moved in contained only basic information regarding how to support people. For example, one person was living diabetes, and although staff were informed of this there was no information regarding how they may present if their blood sugar levels were too high or too low or what action staff should take.

People did not always receive person-centred care. Some people had been prescribed thickener, to thicken their drinks to help them drink safely. People had been prescribed their own thickener, however, staff used one person's thickener for everyone. We saw one person's thickener on a trolley being taken room to room, when people were being offered drinks. We asked staff if people used their own thickener that was prescribed to them and they told us, "We all use whatever is on the trolley."

We also observed staff walking with a trolley filled with incontinence aids from room to room. We spoke with the head of care and asked if people had aids which were specific to them. We were told the service currently purchased aids, however referrals had been made for people to have continence assessments. People had not yet been assessed at the time of the inspection, so were currently not using aids specific to their needs.

The provider and registered manager had failed to ensure that people received care that was delivered in line with their wishes and preferences. This was a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The service regularly supported people at the end of their lives. There was an information leaflet provided for families regarding what they could expect when people reached the end of life stage, and the service had

received positive feedback from relatives regarding the support they had been given. Although this positive feedback had been given only one nurse and the registered manager were trained to use a syringe driver to administer medicine to people to keep them pain free at the end of their life. Although staff told us that the registered manager would be on call if needed there was a risk there may be a delay in people receiving this medicine if they were not immediately available.

Some people had do not resuscitate orders in place and these were seen to be accurate and reviewed when people moved into the service. If required, people were referred to specialist palliative services for additional support. Medicines required to support people at the end of life were at the service, were stored safely and were available when needed. Staff monitored people, they recognised when people were becoming frail and liaised with people's doctors to ensure that people received the care and support they needed. The GP reviewed people's medicines to ensure that they remained appropriate.

The provider had a complaints policy. There had been two complaints since the last inspection. The registered manager had investigated the complaints following the provider's policy. The outcome of the complaint and any action taken was recorded. One complaint had been about people's toiletries being used quickly and people being charged for additional toiletries. The registered manager had limited the people that were able to access additional supplies, this was seen at the inspection, and the action had been successful.

Inadequate

Is the service well-led?

Our findings

At our previous inspection the service was rated requires improvement and we identified breaches of the fundamental standards and regulations relating to safe care and treatment, staffing, dignity and respect and good governance. The provider had reviewed staffing levels since then and increased the number of care staff and changed the way nursing staff were deployed. However, we still found continuing concerns regarding people's safety, the management of medicines and a lack of activities and engagement. The actions the provider told us they had taken following the previous inspection to ensure compliance had not been effective. Staff were task focused, and people did not always receive care that was personalised to them.

The registered manager lacked oversight of the service. Since the change in deployment of nursing staff specific tasks which nurses previously carried out, such as the checking of pressure relieving equipment were no longer occurring. No one had realised that this was the case, until we highlighted it during our inspection. Care staff had been trained and assessed as competent to administer medicines, however, people were not protected from unsafe management of medicines.

This was the registered manager's first role managing a nursing home. They had previously been employed as a nurse in a clinical setting, but never had any responsibility for managing people's needs in a residential setting. They told us there were, "so many things that you don't know until you are told." They were unaware of the importance of analysing accidents and incidents to look for trends and patterns. Since they had taken up post the registered manager had regularly sought advice from the local safeguarding and commissioning teams, and provided information promptly when requested by the Care Quality Commission. They had also sought advice from the local care home nursing team, and attended local forums for other registered managers. However, they had failed to ensure compliance with fundamental standards and regulations. The provider was a Christian organisation, but there was no one with experience of running a nursing home to offer the registered manager guidance and support.

Checks and audits that had been completed had failed to identify the shortfalls found at this inspection. The registered manager and staff completed audits on the quality of the service including staffing, food hygiene, health and safety and medicines. The registered manager had completed a night 'spot' check to observe the night staff in their roles. They had also completed training with staff on the new fire panel. The staffing audit did not look at individual files and check that the files had all the required information and training. The audits had not identified the shortfalls in recruitment found at this inspection. An audit of security had noted that the front doors should only be open between 9am and 5pm, there was no check recorded that staff had been told about this. This had not been adhered to on the day of the inspection, as inspectors were able to enter the service at 7am.

The last medicines audit had been completed in December 2017. Actions had been recorded to rectify any shortfalls found, however, there was no information about who was responsible for checking the action had been effective and when this was to be completed. The infection control audit in February 2018, identified that some chairs were ripped. There was no action recorded or that anybody had been notified about the

issue. There had been no audits completed on the quality of care plans, therefore the shortfalls found at this inspection had not been identified.

The audits were logged as having been completed in the computer. However, there was no record that the registered manager had seen the audits and was aware of the shortfalls.

People, relatives, staff and stakeholders had all been asked for their opinions on the quality of the service in January 2018. The responses had been analysed. People were asked about their care and the choices they were given. Only half of the respondents felt they were able to wake up when they wanted and 30% could get up when they wanted. The previous survey in 2016, people had also highlighted that they were not receiving the care they preferred. The action plan that had been put in place previously had not effective and impacted on people's experience of care at the service.

The staff survey had continued to highlight issues about staffing and the time they were able to spend with people. The registered manager had employed 'resident support workers' to support carers and spend time with people, supporting them with their nutrition and one to one time. There was no plan in place about how to assess if the action had been successful for both staff and people.

Staff attended regular staff meetings. The registered manager discussed with staff about any concerns that had been raised and for any suggestions. The staff meeting held on 8 March 2018 stated that pressure relief equipment needed to be checked and audited. Also that agitation, mood and aggressive behaviour analysis sheets should be started. At the time of the inspection these had not been in place.

The provider had failed to establish and operate systems to assess, monitor and improve the quality and safety of the service and mitigate risks. They had failed to hold an accurate and contemporaneous record regarding each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The registered manager had not notified CQC of important events as required. The police had been contacted and visited the service several times after allegations had been made regarding potential thefts and one person's DoLS had been authorised. CQC had not been notified of these events, as per the regulations.

The provider and registered manager had failed to notify CQC of notifiable events in a timely manner. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider was a Christian organisation, although people did not have to be of the Christian faith to live at the service. The provider's vision for the service was to, 'Provide a warm homely and caring environment, where staff feel valued and we acknowledge and embrace the uniqueness of each resident, whose individual physical, emotional and spiritual well-being needs are met.' Staff told us they wanted to, "Make people feel happy, safe and at home." And, "To make people comfortable. You want to go home and feel like you have done a good job."

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the registered manager had conspicuously displayed their rating on a notice board in the entrance hall and on their website.

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 18 Registration Regulations 2009 Notifications of other incidents The provider and registered manager had failed to notify CQC of notifiable events in a timely manner.

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 The provider and registered manager had failed to ensure that people received care that was delivered in line with their wishes and preferences.

This section is primarily information for the provider

Enforcement actions

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

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 The provider and registered manager had failed to ensure that risks were assessed and mitigated where possible. Systems and processes in place did not ensure the safe management of medicines. The provider and registered manager had failed to ensure that staff had received training to ensure the safe management of medicines.

The enforcement action we took:

We added a condition to the provider's registration to require them to update us on the checks and audits they were completing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and operate systems to assess, monitor and improve the quality and safety of the service and mitigate risks. They had failed to hold an accurate and contemporaneous record regarding each person.

The enforcement action we took:

We added a condition to the provider's registration to require them to update us on the checks and audits they were completing.