Care Quality Commission

Eastern Healthcare Ltd

Brundall Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 09 and 13 July 2015 and was unannounced. Brundall Care Home is a nursing home providing personal and nursing care and support for up to 39 older people, some of whom may live with dementia. At the time of our inspection there were 34 people living at the home.

The previous manager left the home in March 2015. 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. At the time of our inspection a new manager had been appointed.

People told us they felt safe. However, staff did not recognise all of the types of abuse and when these

Summary of findings

occurred they were not reported. Individual risks to people were not properly assessed by staff and actions to reduce, removed or improve the risks to people were not taken.

There were not enough staff available to meet people's needs. This resulted in people having to wait for care and being left unattended. The shortfalls included housekeeping staff as well as care staff and although some action had been taken to refurbish the home, there were areas that were not properly cleaned and that smelt badly.

There had been an improvement in the way medicines were managed. They were safely stored and administered, and staff members who administered medicines had been trained to do so.

Staff members did not receive enough training to provide them with the skills and knowledge to carry out their roles. Staff did not receive any support to discuss individual performance needs or assess their capability.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service was not meeting the requirements of DoLS. The provider had not acted on the requirements of the safeguards to ensure that people were protected. Staff members did not understand the MCA well and best interest decisions to guide staff when people were not able to or how to support the person to be able to make the decision were not available.

People who were at risk of malnutrition or dehydration were not adequately supported to eat and drink enough to prevent this. Drinks were not always readily available. Health care professionals in the community were not contacted about people who were at risk of not eating or drinking enough and other health related issues. This resulted in people not having access to the correct advice and treatment.

Staff were kind, respectful and courteous when speaking with people. However, they did not always know people or their health and care needs well, what people liked and how they wanted to be treated. People's needs were not responded to well and care tasks were not always carried out properly by staff. Care plans did not contain enough information to support individual people with their needs.

A complaints procedure was available and people were happy that they knew how to make a complaint.

Staff morale was low; they had a poor working relationship with each other and with the manager.

The home monitored few records, and these did not properly assess the risks to people and ensure that these were reduced as much as possible. There was a complete lack of oversight from the provider in regard to the running of the home. The provider did not take enough responsibility for ensuring issues were identified and actions taken to improve shortfalls were not adequately monitored or addressed.

You can see what action we told the provider to take at the back of the full version of the report. Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at there.

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.

Summary of findings

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.

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.

People were not supported by enough staff to meet their needs and to keep them safe. People felt safe but staff did not taken the proper actions to keep people safe when abuse had occurred.

Risks had not been properly assessed or acted on to protect people from harm.

Medicines were safely stored and administered to people.

Is the service effective?

Inadequate

The service was not effective.

Staff members did not receive enough training to do the job required, their ability to carry out tasks was not assessed and they were not adequately supervised.

The manager had not acted on recent updated guidance of the Deprivation of Liberty Safeguards and mental capacity assessments or best interest decisions had not been completed for people who could not make decisions for themselves.

Inadequate assistance was given to people who were at risk of not eating or drinking enough. Staff did not work effectively with health care professionals to ensure people's health care needs for people were met.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff members were polite and kind to people but they did not always know people or their care needs well, and people did not always receive the care they wanted in the way they wanted it.

People's friends and family were welcomed at the home and staff supported and encouraged these relationships.

Is the service responsive?

Inadequate

The service was not responsive.

People did not have their care needs properly planned for and staff did not responded appropriately when people's needs changed or deteriorated.

People were given the opportunity to complain, although no formal complaints had been made. Informal concerns were not recorded well, or in a way that ensured the appropriate actions were taken.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

Audits to monitor the quality of the service provided were not completed and areas that required improvement were not identified. Adequate actions had not been taken to address issues.

Staff members and the manager did not all work well with each other or health care professionals, which did not ensure there was good morale within the home.

Brundall Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 09 and 13 July 2015 and was an unannounced inspection.

The inspection was carried out by five inspectors.

Before we visited the home we checked the information that we held about the service and the service provider. For example, notifications that the provider is legally required to send us and information of concern that we had received.

During our inspection we spoke with 13 people who lived at the home and three visitors. We also spoke with 11 staff, including care and nursing staff, kitchen staff, housekeeping and activities staff, the manager and the provider's two representatives. 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. We completed general observations and reviewed records. These included six people's care records, staff training records, 12 medicine records and audit and quality monitoring processes.

Inadequate

Is the service safe?

Our findings

At our last inspection on 19 March 2015 we found concerns in relation to staffing levels. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People had to wait for up to an hour for staff to assist them and there was inadequate supervision of people in communal areas.

The provider wrote to us on 1 July 2015 and told us that they had increased the number of staff members on duty. They also said that they had altered times that staff members took breaks and changed the deployment of staff around the home. They told us that they would become compliant in this area immediately.

During this inspection (July 2015) people told us that staff members answered call bells when they were rung, although we found that they continued to have to wait for help. One person told us that they had chosen to stay in bed that day, although another person told us that they had to wait for staff to become available before being helped out of bed. This person was still in bed at 11am. Two other people told us they did not go out but would love to. They commented, "I have no one to take me out and staff do not have the time" and "I get down in mood sometimes as I cannot get about and staff cannot spend time taking everyone out".

People had to wait for some care. This included people being left unsupervised for long periods of time, people who did not receive assistance at mealtimes and therefore did not eat their meals, or were not assisted with a change of clothing promptly if this became soiled. Few people were up for breakfast by 9.30am but once situated in a communal area they were left alone for over an hour and had no supervision or staff contact for that time. This put them at risk of becoming isolated and in danger of harm as they were unable to call staff for attention. We also saw that nearly half of the people living at the home were still in bed at 11am, putting additional pressure on staff members to check on people throughout the home when they were only staffed at the minimum assessed level.

The home was two, two storey buildings that had been adapted to become one building and consequently there were numerous corridors and rooms located in out-of-the-way parts of the home. This meant that staff took longer to attend to people needs in these areas and left fewer staff available in communal areas, putting people at risk if they needed assistance.

Staff members told us that most people living at the home needed two staff to help them with washing, dressing and getting in and out of bed. All of the staff that we spoke with confirmed that there were two qualified nurses and seven care staff on duty each day as a minimum requirement. The manager told us that agency staff were used to supplement staffing numbers when this was necessary and they thought there were three agency staff working during our inspection but could not be sure of this.

The manager stated that she had assessed that staffing levels needed to be higher. We noted from staff meeting minutes that staff numbers had been higher following the manager's assessment, although they had dropped with the introduction of activities staff from another home. Staff members and the manager also told us that the minimum number of staff were not enough to ensure that people received all of the care they required.

There were no dedicated housekeeping staff employed at the home at the time at the time of our inspection, although new staff had been recruited. Housekeeping was covered by staff from other homes owned by the same provider and we were told that these staff would visit the home every other day until new housekeeping staff started work. This also put additional pressure on care staff each day due to the increased number of tasks they were required to carry out. Dedicated kitchen staff were available, although they were not available to deliver breakfast to people and this responsibility remained with care staff. This put additional pressure on care staff, which prevented them from helping people with care needs.

There were not enough staff to ensure people's needs were met.

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

We found that staff members showed a complete lack of understanding in regard to the abuse categories of neglect and omission of care. Care practices showed that people were not being well looked after and their health care needs were being neglected, resulting in them becoming increasingly at risk of complications of long term illnesses and deterioration in their wellbeing. Although staff

members told us that they understood what abuse was and how they should report any concerns that they had, they also stated that they had not had occasion to do so. We made four referrals to the local authority safeguarding team as a result of this inspection. This meant we could not be confident that staff members would be able to recognise and report safeguarding concerns correctly.

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

Risks to people's safety had been assessed but records of these assessments had not all been fully completed. We identified issues with the quality and accuracy of these assessments. They were individual to each person and covered areas such as; malnutrition, falls, the risk of developing pressure ulcers, and moving and handling. However, we found that some assessments contained conflicting information regarding the size of moving and handling equipment to be used and the level of risk for that person. Where actions to reduce risks had been identified, these were not always followed. We saw that one person had a pressure relieving cushion in their room. There was a notice on the wall of the person's room to remind staff of this as the person had started to develop a pressure ulcer. Despite this, the person was sitting in a wheelchair for an hour and a half and in an armchair for a further hour without the cushion. The person went without this pressure relieving equipment until we intervened and requested that it be used to reduce the risk in accordance with the guidance in the notice.

We found that some risks assessments had been partially completed although there was no guidance regarding the level of risk these identified or any actions staff members should take to reduce risk. This was particularly the case for those assessments in relation to when people had lost body weight and inadequate actions had been taken to ensure people received appropriate advice and treatment. We also found that there was no link between some risk assessments and care plans, and there was no guidance in the assessments for staff to follow if a risk had been identified.

We saw that some people who lived in the home displayed behaviour that might upset others. Staff members described the circumstances that they thought may trigger this behaviour and what steps they would take to keep the person and other people within the service safe. We looked at the care plans for one person regarding this and saw that the information staff members had told us did not match what was written in their care records. Staff could not explain what the guidance meant or the actions they needed to take. This meant that any staff members who were not familiar with a person's needs would not have information to help them care and support that person appropriately.

Risk assessments did not adequately provide guidance or information to reduce the risk to the person concerned and even where information was available, this was not always followed.

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

We had received information of concern from the local authority and the Clinical Commissioning Group (CCG) regarding risks to people in the availability and storage of equipment, and infection control at the home.

The provider told us that they had started to address the concerns highlighted by the CCG in relation to infection prevention and control. New cleaning schedules had been developed and new equipment put into place. Maintenance and refurbishment had taken place to improve and replace areas that were worn or presented an infection control risk. We saw that some areas of the home had been repainted and re-carpeted. However, we were also advised that the home had none of its own cleaning staff and were reliant in the short term on staff from another of the provider's homes visiting every other day to clean until newly recruited cleaning staff started work. During our visit we found that there remained one area in particular where there was a strong offensive odour that still needed to be refurbished and redecorated. Not all kitchen equipment was clean or intact and the kitchen area in general needed a deep clean. Although temporary staff had cleaned around the home while we were there, we noted that people's rooms were not all tidy and one person's room had soil on the floor and dead insects on the window sill.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people we spoke with told us that they felt safe living at the home and that they could talk with staff if they had any concerns. Two comments made to us showed that people felt safe living at the home, "I feel better here than I did at home" and "I am looked after and have no worries

now as when I did living alone". There was a clear reporting structure with the manager and deputy manager responsible for safeguarding referrals, which staff members were all aware of. The provider had reported some safeguarding incidents to the relevant authorities including us, the Care Quality Commission, as is required.

At our last inspection on 19 March 2015 we found concerns in relation to medicines management. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Guidance for staff in relation to giving medicines was not always available or was inaccurate, records were not always maintained properly and some people's medicines were not given in the way that they had been prescribed.

We found there had been an improvement in the management of medicines at the home. People were happy with the way their medicines were given to them and one person told us, "I get my medication when I should and have no worries as the nurses know what I need".

Medicines were stored safely and securely for the protection of people who used the service. We found there was a record of the temperatures of the areas where medicines were stored and these were within acceptable limits. We were therefore assured that medicines were stored in a way which maintained their quality. The cupboard used to store controlled drugs was not of a standard required by the regulations. Controlled drugs are medicines that the law requires are stored in a special cupboard and their use recorded in a special register. We brought this to the attention of the manager and owner who said this would be resolved.

We found there were appropriate arrangements in place to record when medicines were received into the service, when medicines were given to people and when they were disposed of. We looked at the records for 12 of the 34 people who used the service on the day of our inspection. These records were in good order, provided an account of medicines used and demonstrated that people received their medicines as prescribed. However, for one person, one of their medication records could not be found so we could not verify they had been given their medicines. We brought this to the attention of the manager who said they would investigate and started a new form immediately.

We found that where people received their medicine in the form of a skin patch, the site of application was recorded but these records showed that the same site was used within the time period specified by the manufacturer. The usage instructions included with the medicine were that the same site was not to be used within three to four weeks as this could damage the person's skin if the same site was used repeatedly. Staff we spoke with confirmed that they were not aware of this special instruction.

We found that two people were given their medicines disguised in food. We were told that this had been agreed with the person's GP and we found evidence to support this. We also found that this had been discussed and agreed with all parties, for example, family and other relevant health professionals. We were therefore assured that this was done safely and was considered to be in the person's best interests.

Where people were prescribed medicines on a "when required" basis, for example for pain relief, we found there was guidance for staff on the circumstances these medicines were to be used. We were therefore assured that people would be given medicines to meet their needs. We observed medicines being given to some people at lunch time. We saw that this was done with regard to people's personal choice, although this was not recorded as guidance for staff. We heard staff explain to people what they were doing.

The manager told us that they carried out monthly checks on the quality and accuracy of medication records. We looked at the records of these checks that had been completed within the previous four weeks. We were therefore assured that appropriate arrangements were in place to identify and resolve any medication errors promptly.

We spoke with one new staff member who confirmed that checks such as criminal records checks had been obtained before they started work. The recruitment records of staff working at the service showed that the correct checks had been made by the provider to make sure that the staff they employed were of good character.

Inadequate

Is the service effective?

Our findings

At our last inspection on 19 March 2015 we found that assessments of people's capacity to make informed decisions had not been completed. This meant that there was no indication that the service took action to ensure any decisions made on people's behalf were in their best interests. The home had also not been compliant with the Deprivation of Liberty Safeguards (DoLS). This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider wrote to us and told us that they would be compliant with this regulation by 29 June 2015.

At this inspection (July 2015) we found that there had been a slight improvement only. The manager told us that training in the Mental Capacity Act 2005 and the associated DoLS had started to be given to qualified nursing members. Although one staff member was able to appropriately describe how they ensured people were supported to make decisions about their care, we found that staff members' understanding of these subjects was variable. Some staff members who had recently received training did not have a clear idea about capacity and when there may be a need for best interest meetings. One staff member told us that approximately half of the people living at the home had some limitations on their capacity to make decisions.

Care records showed that mental capacity assessments had been completed but only for a very few people. These did not take into account decisions relating to all their care needs where people were not able to make these for themselves.

The provider was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The staff and manager were aware of DoLS and they were aware of when they needed to apply for authorisation if they had to deprive someone of their liberty. Entry doors to the main unit and all external doors were locked and people did not have free access outside the home without a staff member. We saw that a DoLS application had been made for one person, however no assessment had been made to determine how many other people might require DoLS authorisations. The manager confirmed that they had yet to do this, despite other people living at the home whose liberty was restricted.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received information prior to our inspection in regard to staff training and concerns that staff members did not all have the skills to properly care for people.

Most of the staff we spoke with told us that they had received some training to meet the needs of the people who lived at the service and to ensure they were able to carry out their roles safely. However, one staff member also told us that the whole staff team needed more training. Staff who we spoke to said that they had undertaken training, such as moving and handling, fire safety, food hygiene or infection control, as a minimum and training records confirmed this. We found that not all staff members had received this training and there were other areas where staff had not received additional training that was appropriate to their role. For example, a member of the kitchen staff had not received training in moving and handling, safeguarding or infection control.

Nurses were responsible for monitoring blood sugar levels in people who lived with diabetes. However their skills in this area had been identified as needing to be updated. Although an appropriate health care professional had been contacted to carry out this training and had provided a DVD when they were not able to provide training in person, no action had been taken to source other training to ensure staff were competent in this area. We found that people with diabetes did not have this properly managed by staff working at the home, which put them at serious risk of developing irreparable complications.

Although staff members cared for people who lived with dementia and some people showed behaviour that may upset others, no training had been provided in relation to this. A staff member stated that for one person, this had an effect on how their personal care was given to them. However, they were not able to describe to us how they managed to provide this if the person refused for staff to assist them. The manager told us that training in these areas were being scheduled, although no staff had received any training at the time of our inspection. Another staff

member told us that staff were not able to meet the needs of people who displayed behaviour that may upset others. This placed both people using the service and staff members at risk of harm.

The local authority and Clinical Commissioning Group had identified other areas where staff members required training, although little had been done to source training providers for these. Some staff had started distance learning courses, although this was not appropriate training for all staff. Staff competency was not checked following any training they received as staffing levels did not allow the senior staff member who had been responsible to continue with these checks. This meant that the provider or manager could not be assured that staff members had learnt from training they had received or were working in the way that they had been trained to.

Staff told us that they had received no supervision meetings with their line manager in which they could raise any issues they had and where their performance was discussed. Staff records showed us that supervision meetings were not formally held, but where there had been a discussion this had been recorded in a brief note only. Nurses received inadequate supervision to ensure they carried out their role effectively. There was no evidence to show that all options to promote people's health and wellbeing, such as for people with weight loss or diabetes, were considered or acted upon. This showed that these staff members did not have the skills or knowledge to properly care for people.

We concluded that although some staff members had received training, there were too many gaps in the training that had been provided. This did not ensure that staff members had the skills and knowledge to carry out their roles properly and to be able to care for people safely. Staff members' skills were not properly assessed and they were not given the appropriate supervision and support to enable them to carry out their roles.

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

People and their visitors told us that the meals provided at the home had improved and that the food was good. However, two visitors also told us that the support their relatives received from staff was not enough to ensure they were able to eat and drink adequate amounts to prevent them from losing weight or risking dehydration.

A choice of food and drink was available for people. We saw that staff members reminded people what they had chosen the day before but that there were no other visual aids or prompts for people. A large number of people living at the home lived with some memory loss and for those people, this meant that they received meals that they may not have been expecting or may have changed their mind about.

We observed the lunchtime meal in both main dining areas of the home and we found that people's experiences varied. The meal was served late and people had to wait for up to 45 minutes to be given their meals, although the manager told us that this was not usually the case. Meals were delivered pre-plated and there were no condiments available on tables. This meant that people did not have the opportunity to decide how much they wanted of something, such as gravy. Most staff assisted and supported people appropriately by sitting next to them, explaining what the meal was and asked whether they were helping people at a pace that suited the person. However, we also saw a staff member stand over one person while they helped them, with little verbal communication except to ask the person to open their mouth. They did not provide eye to eye contact or other encouragement. We observed that two people did not receive any verbal or physical support to eat their meals and these remained untouched by the people during our observation of the mealtime.

The amount of food and drink being consumed by people who were at risk of, or had a low body weight, was not being recorded properly. This did not ensure they received as much food as they needed to maintain or increase their low weights. For example, for one person who only ate one teaspoon of food for breakfast, information in the food chart showed that they had eaten 'some' of the food. In fluid records, the amount of fluid drunk was written as, 'most of a cup of tea'. We saw in one person's care records that a desired daily drink intake had been identified. However, this was any amount between one and a half and two litres, which meant that the guidance was not specific enough to enable staff to ensure the person remained hydrated. Fluid records showed that this person frequently drank less than 500ml each day, which meant that they were receiving less than a third of their desired minimum drink intake and that they would have been at risk of dehydration. No action had been taken in response to this and the person remained at significant risk of not drinking enough.

Inadequate

Is the service effective?

Insufficient time was spent with people to ensure they received enough to eat and drink. No or inadequate action was taken when people did not eat or drink enough and there were people who were at risk of becoming malnourished as a result.

This was a breach of Regulation 14 of the Health and Social Care (Regulated Activities) Regulations 2014.

We received information prior to this inspection that people did not have adequate access to the advice and treatment from health care professionals.

Records showed us that referrals were made to people's GPs, although issues affecting their health were not always passed on to the GP during these visits. Some people's health issues were not reported to the person's GP at all.

We found that people with diabetes were most at risk in this regard. We examined records for people with diabetes. We found that there was not always enough information to show how this affected the person or what their normal blood sugar range was. There was no information about what staff members should do if the person's blood sugar level was outside of this range. Blood sugar levels were not always recorded on a consistent basis as there was conflicting information in the care plans. No action had been taken when blood sugar levels were recorded above either national guidance for desired blood sugar levels or the person's own blood sugar range. No action had been taken to refer these people to health care professionals for advice or treatment. This put them at an unacceptably high risk of developing complications associated with ongoing high blood sugar levels.

Not all people who had suffered a continued weight loss over several months had been referred to their GP or another health care professional as soon as their weight loss became a concern. We saw that another person had fallen frequently but no referral had been made to a falls team in relation to this. This inaction put people at risk of developing complications from poorly or untreated medical conditions, or of not receiving appropriate intervention to prevent further deterioration or an injury.

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

Requires improvement

Is the service caring?

Our findings

At our last inspection on 19 March 2015 we found concerns in relation to how people were treated, particularly in regard to the clothing they wore, being rushed during mealtimes and not having things explained to them before tasks were carried out. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider wrote to us on 1 July 2015 and told us that they would become compliant with this regulation immediately.

During this inspection (July 2015), we found that there had been some improvement in how people's privacy and dignity was maintained, but that there continued to be concerns. We saw that people continued to be left in clothing soiled during mealtimes for several hours following their meals. Although people received support with personal care, we saw some people still had dirty fingernails following this. This means that care was rushed and adequate time had not been taken to make sure people were properly clean. Although most people had footwear on, many people had no socks or tights.

Although staff members we heard speaking with people respected their decisions, they did not all act on people's requests at the time the request was made. Staff members did not take questioning further to ask what people wanted to do during the day. In one lounge this meant that the people there had nothing to do or listen to and they were left to sit in silence for an hour. Additional staff from another home arrived after an hour, however none of the people in the lounge received any stimulation until the television was turned on after another hour. One person's visitors told us that staff did not have the time to interact with their relative. They said that this also meant that people were left alone for long periods in communal areas, which resulted in people arguing between themselves.

All of the people we spoke with were happy with the staff members and with living at the home. One person said, "Staff are good" and another person told us, "Staff will make sure I am alright". However, none of the people we spoke with could remember whether they had been involved in planning their care. They did not know about their care plans or what they contained. Relatives told us that they were not always involved in their loved ones care. One visitor told us that they had difficulty understanding some staff and two other visitors told us that they had to take the initiative or they would not be involved in their relative's care.

We saw during our inspection that some people did not have all of their health and care needs met. Staff members had not taken the appropriate actions to ensure these people were properly cared for and this did not ensure people were treated with dignity and respect.

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

Staff sometimes involved people in their care. We observed them asking people where they would like to sit and whether they wanted to wear protective garments at meal times. One person told us that staff were, "Helpful and cooperative". They said they were able to choose when to get up and go to bed. They thought staff members tried hard to please people.

Although we had concerns in relation to how people were cared for we also found areas of good practice. We observed conversations with people that were kind, respectful and appropriate. Explanations were provided when people needed these.

Most staff members made eye contact with people and crouched down to speak to them at their level so as not to intimidate them. When asked, staff members demonstrated a good knowledge about how people communicated different feelings such as being unhappy or in pain so that they were able to respond to these.

We observed some examples of staff respecting people's dignity and privacy. They ensured that curtains were pulled and doors were closed when providing personal care and knocked on people's doors before entering their rooms. We saw that no-one was uncovered or in a compromising position. However, there were un-obscured views into some people's bedrooms on the ground floor, which meant that people could be seen from public outside areas of the home or from the road.

The manager told us that information in relation to the people's individual life history, likes, dislikes and preferences was in the process of being obtained as care

Requires improvement

Is the service caring?

records were being reviewed and updated. Staff were able to demonstrate a knowledge of people's individual preferences, although these preferences had not all been acted upon.

Inadequate

Is the service responsive?

Our findings

At our last inspection on 19 March 2015 we found concerns in relation to care plans that were not person centred or individual to each person. People's social needs were not met. Staff did not take the appropriate actions to reduce people's anxiety and not all people received the appropriate care to reduce their risk of developing pressure ulcers. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider wrote to us and told us that all care files would be reviewed and rewritten. They said that they would complete this by December 2015.

We also received information of concern prior to this this inspection that people were not receiving the care that they needed in order to ensure their physical and nursing needs were being met.

During this inspection (July 2015) we found that people were not receiving the care they required to meet their care needs.

Where there was information about how people should be cared for, this was not always followed. People did not always receive the correct care to reduce their risk of developing pressure ulcers, or of becoming malnourished. Pressure relieving equipment was not always used and although most staff were attentive and assisted people appropriately during mealtimes, we found that not enough actions to increase people's dietary intake had been identified. For example, evaluation of care plans did not recognise initial weight loss. No actions were taken about people who had a lack of appetite. Care plans did not mention any further weight loss and did not provide any guidance except that staff members should encourage the person to eat. The manager told us at the beginning of our visit that there were no people with pressure ulcers living at the home. One person, whose experience of living at the home we followed, had started to develop a pressure ulcer.

We observed that a staff member had to physically help a person to eat but as soon as the person refused to eat anything further, no more assistance was offered and staff did not return at a later time to offer anything else. We spoke with the person's relative and a staff member regarding nutritional supplements that had only been provided in the two weeks prior to our inspection. They were both aware of the person's flavour choice, although this information was not written in any care records and the person was not receiving this flavour.

One person we met used oxygen through a concentrator and had an oxygen cylinder in their room for back-up in case of electrical failure. We asked nursing staff about the oxygen and what actions they took to ensure it was delivered in a safe way. They were aware of the level of oxygen that should be delivered but they were unable to tell us any of the checks that should be completed and how often this should be done. One nurse told us that although checks were carried out on face masks and nasal cannulae for debris, these were not recorded anywhere and they were not sure how often they were changed. We also noted that equipment checks and cleaning had not been completed and that staff were not aware of any guidance regarding this. They explained that they thought this would be at the discretion of the supplying company, although they did not know whether there was information to this effect. This placed the people receiving oxygen at an unacceptable risk of machine or equipment failure.

Staff members told us that it was the nursing staff and manager's responsibility to write care plans and to review and evaluate these. This process had been started, although we saw that there continued to be considerable shortfalls in the quality of these records. Quick reference information had been introduced to people's rooms to ensure that guidance was easily available for all staff members. However, a member of care staff told us that they did not read care plans and were told about people's needs by word of mouth.

Needs assessments had been completed, although most of these were brief and did not contain enough detail to ensure staff members were able to meet all identified needs. We also saw that of all the assessments available in care records that we examined, only one had been dated and signed by the person carrying out the assessment. The manager was unable to tell us when the assessments had been completed and it was therefore not possible to tell whether people had their needs assessed before coming to live at the home. It was also not possible to tell which assessment was the most recent and therefore which information was accurate and most relevant.

We observed that few staff members were able to spend time with people to meet their social needs. Additional

Inadequate

Is the service responsive?

staff members had been brought in from another of the provider's homes to spend time with people. We saw that both of these staff members spent time with one person in an activity but that they did not include anybody else in their interaction. Our observations showed that most people in communal lounges spent their time with little stimulation from staff members. This resulted in many people becoming withdrawn and going back to sleep shortly after they had got up. We spoke with one person's visitor who told us that staff members did not have the time to interact with their relative.

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

People told us that they were happy living at the home and they said that staff tried hard to look after them. However, we saw that people were not always cared for properly or had all of their care needs met.

People's visitors told us that they were listened to and that staff members responded to their requests, concerns or complaints. We found that there was information available in the event that people were not happy and wanted to make a complaint. The service had received no formal complaints since our previous inspection in March 2015, although informal complaints and concerns were not well documented. Visitors to the home told us that concerns or suggestions were quickly acted upon. However, these were not recorded consistently and therefore staff were not able to check whether issues were recurring or whether action taken was appropriate.

Inadequate

Is the service well-led?

Our findings

We received information prior to this inspection in regard to the recent change of manager and concerns about how the home was being managed.

The home had a recent change in manager, with the new manager taking up the post six weeks before our inspection. The previous registered manager had left the position following our inspection in March 2015 and had cancelled their registration with us in June 2015. Visitors to the home told us that they felt improvements had been made since the new manager had started working at the home. However, during the course of our inspection the provider's representative advised that this manager had resigned from the position.

The manager provided us with an action plan regarding how concerns identified at our previous inspection in March 2015 were being addressed. This showed that although actions had been identified, there were no timescales to show when they would be completed. There was no other information to show that the most serious concerns were dealt with first.

The manager completed audits, although these were limited to infection control and medicines. They did not include care records, which was because these were being reviewed and updated. No other audits were completed to show how the quality of the service was assessed and monitored to ensure there had been and continued to be improvement. We examined accident and incident records as the manager told us that this information was collated each month for monitoring purposes.

We found that the information had indeed been collated, although investigation into accidents and incidents was not thorough and inadequate action had been taken with the information. For example, one person had had 24 falls in the preceding six months and the manager agreed that this should have triggered a referral to an appropriate health care professional. However, this had not been identified as an action and the manager did not think that this action had been taken. One accident report for this person showed that they suffered a head injury. The follow up action identified by the manager indicated that staff had taken appropriate action to deal with a head injury. However, when we looked into this, the provider's policy and procedure did not contain any guidance in relation to head injuries.

None of the auditing or monitoring information had identified the issues that we had found during our inspection. We spoke with the provider's representatives, who expressed surprise at the extent of our concerns as they had not been made aware of issues by either the previous registered manager or the manager at the time of our inspection.

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

Staff members spoke to us of the low morale and lack of support within the whole staff team. They told us that this was because the work was hard, there were not enough staff and there had been a lot of criticism about the home recently. One staff member said that morale was also low because staff members did not like change and that there had been changes to the way and where staff worked in the home. Staff meeting minutes indicated that staff members were not working well together. There had been poor unity between different staff groups and within one staff group between differently experienced staff members.

Staff said that they were kept informed about matters that affected the home through meetings, although these had not occurred as frequently as the manager had initially indicated. The most recent staff meeting minutes were available and detailed changes that had been planned when the manager first came into post. However, there had been no further update for staff since the beginning of June 2015. These showed that staff had been provided with some guidance regarding what was expected of them. Although it did not ensure that they had been kept abreast of whether changes had improved the experience of people living at the home or other actions that needed to be considered. There was no monitoring of whether these changes had been implemented within all staff groups. We found that nursing staff in particular had not taken on a leadership role and this had resulted in a lack of responsibility being taken to ensure people received the appropriate care.

Staff members had varying opinions about the manager, one staff member told us that the manager had not introduced herself to staff and that they did not spend time

Inadequate

Is the service well-led?

with staff members. Another staff member told us that the manager was more approachable, had made lots of changes and that they could see how these would work to improve staff morale. The manager told us that they had identified that staff members did not all work well together and that one group in particular were not working effectively. Actions, such as introducing separate teams for each area of the home and asking one group of staff to take on more responsibility, had been put into place to try to improve this. It was clear during the inspection that staff members worked in isolation and there was a lack of organisation of workload.

The provider's representatives visited the home every week to check on how the home was running. As the provider had only started these visits recently, limited information was available for assessing and monitoring purposes. We found that there had been inadequate oversight by the provider regarding the running of the home.

People told us that they were happy living at the home and made comments such as, "I like living here". Visitors that we spoke with said that there had been an improvement since the manager had come into post. However, no-one we spoke with could remember being asked their opinion of the home. No formal questionnaires had been sent to people or their relatives, although there had been two resident and relative meetings since the beginning of the year. The most recent meeting showed that people had been made aware of the concerns about the home and provided them with an opportunity to share their views of the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services were not protected against the risks associated with unsafe or inadequate care because of lack of guidance about meeting people's needs. Regulation 9 (1)(a), (b), (3)(d), (f)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People who use services were not protected against the risks associated a lack of respect in relation to inadequate care. Regulation 10 (1).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

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 People who use services were not protected against the risks associated with unsafe and inadequate assessment of and action to reduce identified risks. People who use services were not protected against the risks associated with the lack of access to advice or treatment from a health care professional. Regulation 12 (1), (2)(a), (b).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People who use services were not protected against the risks associated with a lack of consent, application of the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1), (4).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who use services were not protected against the risks associated with inadequate support to prevent malnutrition and dehydration. Regulation 14 (4)(a), (b), (d).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services were not protected against the risks associated with unclean premises. Regulation 15 (1)(a).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

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

This section is primarily information for the provider

Enforcement actions

People who use services were not protected against the risks associated with unsafe and inadequate monitoring and assessment of the quality of the service provided.

Regulation 17 (2)(a), (b).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services were not protected against the risks associated with the inadequate number of staff available to meet their care needs and to keep them safe. People who use services were not protected against the risks associated with the inadequate provision of training and supervision for staff members to ensure their health and care needs were properly met. Regulation 18 (1), (2)(a).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were not protected against the risks associated with a lack of understanding of all types of abuse and disregards the needs of the service user. Regulation 13 (4)(d).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.