

Bupa Care Homes (ANS) Limited

The Cambridge Nursing Centre

Inspection Report

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Summary of findings

Overall summary

The Cambridge Nursing Centre is a care home providing accommodation and nursing care for up to 90 adults. There were 81 people living there when we visited. The care home provided a service for people with physical nursing needs and for people who lived with dementia. There was a manager registered at the service who assisted us on the day of the inspection.

We found that not all aspects of the home were safe.

Where people lacked capacity to make decisions, the Mental Capacity Act 2005 was not being fully adhered to, to ensure staff made decisions based on what was in people's best interests.

Systems in place for the cleanliness and hygiene of the home did not protect people from acquiring a health care related infection.

People were not always receiving their medication as prescribed and staff were not effective in supporting people when people who displayed behaviour which staff may find challenging became agitated or upset.

We found improvements had been made to the frequency staff were being given training and we saw that staff recognised the importance of supporting people with privacy and dignity. The changing needs of people were sometimes recognised and planned for, with the appropriate referrals to external health professionals made. We saw that there were plans in place for people to receive end of life care.

However we found that people were not always supported to maintain good nutrition and hydration. Some risks in relation to mobility and pressure ulcer prevention and care were not being managed appropriately.

We received some positive comments about the staff and the care people were receiving and we saw some good interactions between staff and people living in the home, including one person who refused their meal. The carer was very concerned, fetching several different options in the hope the person would eat something. Eventually, the carer said, "I know they like sweet things" and went and got rice pudding with jam.

However some of our other observations were not as positive. For example, one person we found was distressed and had been left with their medicines as the nurse had told them not to take them until they returned. The nurse however had forgotten to return.

Some people we spoke with were not aware of how to make a complaint. However we saw that when people did make a complaint these had been investigated and responded to by the manager in line with the complaints procedure.

People we spoke with told us that they were able to make everyday choices. However our observations did not support that people were always given choices. For example, we observed one person saying that the tea wasn't sweet enough but they were not offered any more sugar. We also observed the same person at lunchtime asking for a tea with more sugar but this was again not responded to by staff.

We found there were not enough meaningful activities offered to people which would meet their individual needs. All of the people we spoke with said either that they were unaware of any activities or that there was, "not much going on." We received comments such as this from people in all of the four units of the home. We also had concerns about the risk of social isolation for people who were in their bedrooms for long periods of time.

We found there had been some improvements to the provider's systems of monitoring the quality of the service in some areas but the systems were still not effective. Although there were visits made by the provider's quality team and the manager also completed audits in the home, these had not identified the concerns we found during this inspection.

We found there was no system in place to show how staffing levels had been assessed to ensure that numbers were sufficient to meet the needs of the people who used the service and all of the people we spoke with raised concerns about the low numbers of staff in the home. One person told us, "They [staff] often do not come quickly enough when I ring the bell and I get so desperate I end up having to urinate into my pads."

Summary of findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. (The deprivation of liberty safeguards are a code of practice to supplement the main Mental Capacity Act 2005 Code of Practice.)

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The manager told us there was no one living in

the home currently that needed to have these safeguards in place. However we saw evidence to suggest that two people who lived in the home were being deprived of their liberty.

We found the location was not meeting the requirements of the Deprivation of Liberty Safeguards.

We found there were a number of breaches in regulation of the Health and Social Care Act 2010 at The Cambridge Nursing Centre and you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

When we inspected the service in August 2013, we found concerns in relation to the cleanliness and hygiene of the home. We asked the provider to send us an action plan and tell us what they would do to make improvements. When we inspected the home again in December 2013 we found there had been some improvements but there were still some concerns.

During our visit we found significant infection control issues. We found the home and equipment were not clean, hygienic or well maintained. We saw that some people's bedrooms and en suite bathrooms and communal bathrooms were not cleaned effectively.

We found that medication arrangements were not safe. For example, we saw there was a risk of people being given their medication doses too close together as when medicines were given at different times to those printed on the medication record forms, the actual time it was given was not recorded. We also found staff signature omissions in the recording of whether people had received their medicines as prescribed and we found that there were not clear procedures in place when people needed to have their medicines given in a certain way. This meant we could not be assured people were receiving their medicines as prescribed and this could have an impact on their health and wellbeing.

We spoke with six people who lived in the home and they all told us they felt safe. The four relatives we spoke with told us they did not have any concerns about their loved ones safety at the home, nor any concerns about bullying from staff. We saw there were systems in place to protect people from some types of abuse and staff knew how to recognise and respond to abuse. However, although staff were trained in dealing with behaviour which could be challenging, they did not always respond to such behaviour appropriately.

Staff had completed training in the Mental Capacity Act 2005 and staff we spoke with had knowledge of the Act. However the appropriate assessments of people's capacity and ability to make decisions for themselves had not been completed. This meant people were not always fully involved in decisions about their care and treatment.

Summary of findings

Are services effective?

We found that staff training had been improved since our inspection on 14 August 2013 and that staff had been given recent training on different aspects of care delivery such as how to safeguard vulnerable adults from abuse.

Information about advocacy was not displayed in the home and the manager told us they did not have any information in the home informing people how they could access an advocate if this was needed. Advocates are trained professionals who support, enable and empower people to speak up.

We found mixed evidence across the home in relation to how people's health care needs were assessed, planned for and delivered. Records showed that people had access to health care professionals such as GP, physiotherapist, chiropodist, optician and dentist on a regular basis.

Risk assessments for pressure care, falls, personal safety and mobility and nutrition were in place and had been regularly reviewed. There were care plans in place for the assessed risks, informing staff how to support people and minimise the risks. However we found staff were not following these in a consistent way. For example, where people had pressure sores or were at risk of pressure sores, there were not always effective processes in place to minimise the risk of people developing a sore and nurses were not always treating pressure ulcers appropriately. This meant there was a risk of people developing a pressure ulcer.

Care plans were not always up to date with people's needs in relation to mobility and staff were not always using safe practice when assisting people to mobilise.

Some people had been assessed as being at nutritional risk and staff were not always taking the appropriate steps to support them with their nutrition. We found three people who were not being given the support needed to maintain their nutrition.

We observed some positive practice with staff supporting people with their nutrition. On one unit in the home, we saw two occasions where people did not eat sufficient amounts and staff provided alternatives of their favourite foods to tempt them to eat.

We saw examples of where staff had recognised people's changing health needs and put plans in place to address these. For example one person with complex health needs had been referred to several specialists when their health needs changed.

Summary of findings

Are services caring?

We received some positive comments about the staff and the care people received. One person told us staff were, “Marvellous.” Another person said, “Staff are kind and compassionate, the girls are marvellous, very respectful, I never feel embarrassed, I think the world of them.” A relative said, “Staff could not be kinder.”

Staff had been trained in how to respect people’s privacy and dignity and the staff we spoke with had an understanding of how they needed to put this into practice. We saw staff respecting people’s privacy and dignity when supporting them with their personal care and by knocking on doors prior to entering their bedrooms.

People told us they felt their privacy and dignity were respected by staff at the home. One person said, “The staff give personal care very discreetly, I always feel my privacy and dignity are respected.” This person was able to give us an example of what staff had done to alleviate their embarrassment in relation to personal care.

However our observations did not always support what people had said. We saw that the care was mostly task orientated and that staff did not always focus on people as individuals. We saw this caused distress to two people living in the home during our visit.

The care plans we looked at were mostly health and risk based. The plans told staff very little about people’s preferences or personal history and only contained sparse reference to the person as an individual.

We saw that there were plans in place for people to receive end of life care. One person, who was receiving end of life care, had appropriate plans in place for staff to follow to keep the person comfortable and pain free. This meant the person would be supported to be comfortable when their health deteriorated and they reached the end of their life.

Are services responsive to people’s needs?

Some people we spoke with were not aware of how to make a complaint. One person told us, “I have been given very little information and do not know who to speak to with regards complaints.” However we saw that when people did make a complaint these had been investigated and responded to, in line with the complaints procedure.

People we spoke with confirmed that they were able to make everyday choices, and relatives of people with a dementia related illness said that this was also the case and that their family member’s choices were respected. However our observations did not support that people were always given choices. For example, we

Summary of findings

observed one person saying that their tea wasn't sweet enough but they were not offered any more sugar. We also observed the same person at lunchtime asking for a tea with more sugar but this was again not responded to by staff.

We found there were not enough meaningful activities offered to people which would meet their individual needs. All of the people we spoke with said either that they were unaware of any activities or that there was, "not much going on."

We raised concerns with the manager and a member of staff in relation to the number of people who were assisted into bed after lunch. Two of these people had been assisted into nightwear and into bed at 2.30 in the afternoon and there was no rationale for them being in bed recorded in their plan and staff were not able to offer us an acceptable explanation. This placed these people at risk of social isolation and health related risks such as developing a pressure ulcer.

Are services well-led?

When we inspected the service in August 2013, we found concerns in relation to the systems in place to assess and monitor the quality of the service. We asked the provider to send us an action plan and tell us what they would do to make improvements. When we visited the home in April 2014, we found that there had been some improvements in some areas but the systems for monitoring the quality of the service were still not effective.

Prior to this visit we asked health and social care professionals who knew the home for their opinion of the service. We were told that there had been some concerns about staffing levels in the home. We found there was no system in place to show how staffing levels had been assessed to ensure that numbers were sufficient to meet the needs of the people who used the service. We spoke with six people who lived in the home, and four relatives across all units and all of them told us they felt there should be more staff. One person told us, "They [staff] often do not come quickly enough when I ring the bell and I get so desperate I end up having to urinate into my pads."

Although there were visits made by the provider's quality team and the manager also completed audits in the home, these had not identified the concerns we found during this inspection. This meant the systems in place for monitoring the quality of the service were not effective in identifying concerns and improving the service.

We saw there were meetings held between the manager and staff at all levels in the service and information was shared between management and staff to promote an inclusive environment and establish effective methods of communication.

Summary of findings

We saw there were plans in place for emergency situations such as an outbreak of fire. Staff understood their role in relation to these plans and had been trained to deal with them.

Summary of findings

What people who use the service and those that matter to them say

We found that there were quite contradictory accounts of this service from the people we spoke with. Some people and their relatives were very happy and some not quite so pleased. All six people that we spoke with complained about a lack of staff and a timely response when answering call bells. However, our observations and the records we looked at did not always match the positive accounts people gave of the care they or their relative had experienced.

The staff we observed some staff carried out their role with kindness but we saw that not all staff showed an interest in the people living in the home and treated them as individuals. We particularly saw this on the Downing unit of the home. We saw that some people were left in distress and people with dementia related illnesses were not always given appropriate support.

All except one person we spoke with commented positively on the food served. One person said, "The food is good, there is always a lot of choice. The fruit salad is particularly excellent, at least six really fresh fruits. I have put on weight since I have been here." One person commented the food was not always hot when served in their bedroom.

We received many positive comments about the staff. One person told us, staff were, "Marvellous." Another person said, "Staff are kind and compassionate, the girls are marvellous, very respectful, I never feel embarrassed, I think the world of them." Another person said, "I don't like accepting personal care from anyone, but under the

circumstances staff make it the best it can be. They couldn't do more to put me at my ease and they always make sure the door and the curtains are tight shut." One relative told us they very pleased and since their relative had moved into the home they were, "much happier now, a real improvement." Another relative said, "Staff could not be kinder."

People told us they felt their privacy and dignity were respected. One person said, "The staff give personal care very discreetly, I always feel my privacy and dignity are respected." This person was able to give us an example of what staff had done to alleviate their embarrassment in relation to personal care.

Everyone we spoke with raised concerns about staffing levels in the home. One person told us, "They [staff] often do not come quickly enough when I ring the bell and I get so desperate I end up having to urinate into my pads." This person told us they had needed assistance from staff in the middle of the night but despite ringing their bell, had been "left in my own mess" for two to three hours. On other occasions this person told us they been left sitting on the commode for long periods of time. Both this person and their visitor said that they believed there were not enough staff, "Even on a quiet day." The relative told us, "They simply cannot cope. Every time my relative rings her bell, they are asked [by staff], 'Can it wait? This is because staff are busy attending to someone else, and at least 15 minutes goes by before someone comes back.'"

The Cambridge Nursing Centre

Detailed findings

Background to this inspection

We visited the home on 14 April 2014. We spent time observing care and support in the lounge and dining areas. We looked at all communal areas of the building including the kitchen, bathroom, activity room and also people's bedrooms. We also looked at some records, which included people's care records and records relating to the management of the home.

The inspection team consisted of a lead inspector, two further inspectors, a pharmacist inspector, a specialist nursing advisor and an expert by experience of older people's care services. An expert by experience has personal experience of using or caring for someone who uses this type of care service.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave one.

Before our inspection we reviewed information we held about the home. We examined notifications received by the Care Quality Commission and we contacted the commissioners of the service to obtain their views on the service and how it was currently being run.

On the day we visited we spoke with six people living at The Cambridge Nursing Centre, four relatives, three nurses, four care staff, the registered manager and the regional manager.

Are services safe?

Our findings

When we inspected the service in August 2013, we found concerns in relation to the cleanliness and hygiene of the home. We asked the provider to send us an action plan and tell us what they would do to make improvements. When we inspected the home again in December 2013, we found there had been some improvements but there were still some concerns.

We looked at the infection control systems in place during this inspection and we inspected the home to ensure that rooms, including bedrooms, bathrooms and communal living areas were clean and equipment was clean. We saw that an infection control audit had been completed in January 2014, and had identified some shortcomings. An action plan was in place to address those shortcomings. However, during our inspection we found significant infection control issues. We found the home and equipment were not clean, hygienic and well maintained. We saw that some people's bedrooms and en suite bathrooms and communal bathrooms were not cleaned effectively.

We saw that equipment used in the home, for example armchairs, wheelchairs and walking frames was not clean. We also found that some equipment, like bedside protectors, pressure cushions, and carpets required replacement so that it could be cleaned to a high standard. We found that some parts of the home smelt of urine, especially Downing unit. These issues meant that people who used the service, staff and other people were placed at significant risk of acquiring or transferring infections.

This meant there had been a breach of the relevant legal regulation (Regulation 12 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

We found medicines were stored safely, for the protection of people who used the service. However, we found that medication arrangements were not safe. We noted arrangements were in place to record when medicines were received into the service, given to people and disposed of. Records provided an account of medicines used, but we found that when medicines were given at

different times to those printed on the medication record forms, the actual time it was given was not recorded. This meant that people were at risk of receiving medicines too close together to be safe.

We looked at the medicine records for 28 people and found omissions in 19 of them. In several records we looked at, there was no reason recorded for why someone had not received their medication from staff as prescribed. For example the medication record for one person was left blank on two separate occasions in relation to medication prescribed for their diabetes.

We also found some unexplained staff signature omissions in the records of medicines given to people that hadn't been identified by the service's own audit system. We were therefore not assured that systems were in place to identify and resolve any medication errors promptly.

Where people received their medicines in the form of a skin patch, we found the site of use wasn't documented so that staff could alternate the site to minimise the risk of skin damage. We also found that special instructions for giving medicines were not being followed by staff. We found evidence of special instructions not being followed by staff for six people. For example, "take at least 30 minutes before the first food, drink or medicine of the day." We were therefore not assured that people were given their medicines in a safe way.

We saw one person had paracetamol prescribed by their GP. This was recorded twice on the Medication Administration Record (MAR) with instructions to administer two 500mg three times a day, and then further instructions to administer as and when required. The person also weighed less than the recommended safe weight for receiving this amount of paracetamol in a 24 hour period. This meant there was a risk of this person receiving an overdose of paracetamol.

This meant there had been a breach of the relevant legal regulation (Regulation 13 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

We spoke with six people who lived in the home and they all told us they felt safe. The four relatives we spoke with told us they did not have any concerns about their loved ones safety at the home, nor any concerns about bullying from staff.

Are services safe?

People who used the service were protected from the risk of abuse from staff because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff told us they had received recent training in safeguarding vulnerable adults and training records confirmed this. We spoke with two members of staff and they were able to tell us how they would respond to allegations or incidents of abuse and they knew the lines of reporting in the organisation. We saw written evidence that the manager had notified the local authority and us of safeguarding incidents.

We saw staff had been given recent training in relation to managing and responding to people's behaviour which might challenge. However people were not always kept safe from other people who lived in the home because staff did not respond appropriately to potentially abusive situations. One person living with dementia was showing signs of unrest and mistakenly thought another person who lived in the home was their daughter. This led the first person to become agitated when they did not get the responses they thought they should, and we had to intervene to ensure the person's safety. Another person was becoming agitated and asking several members of staff if they could visit or telephone their mother. These situations were not managed by the staff and they did not follow the guidance in individual care plans about how they should support individuals when they were confused and showing behaviour that was challenging others. This resulted in both remaining in an agitated state.

The manager told us that Fitzwilliam unit was for people who lived with dementia and who also had behaviour that challenged others. We carried out an observation in the communal areas of the unit. We found that the staff numbers on duty were insufficient to ensure safe practice. We witnessed one person becoming angry with the person sitting next to them and raising their voice at them and the second person then became upset. The first person then comforted the second person. However all of the staff were busy working with other people and the incident was not noticed by any of the staff. This meant people were at risk from other people living in the home.

Staff did not follow a person's care plan when they became upset and angry and tried to leave the unit to go home. One member of staff took hold of the person's arm and tried to guide them back into the unit, even though they were clearly saying that they wanted to leave which

resulted in the person hitting the member of staff. We asked if a Mental Capacity Act deprivation of liberty safeguards application had been made and we were told that it had. However when we asked to see the written information we found no deprivation of liberty application had been made to ensure the person was protected.

We saw that the care plan for one person in relation to their 'mental state and cognition' stated that there were no episodes of agitation or unsociable behaviour. However the person's pre-admission assessment stated that the reason for them moving into the home was because of increased anxiety levels and the impact this was having on people at their previous home. We also observed them becoming agitated and trying to take off their underwear in communal areas of the unit.

This meant there had been a breach of the relevant legal regulation (Regulation 11 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The manager told us there was no one living in the home currently that needed to have these safeguards in place. However we saw evidence to suggest that two people who lived in the home were being deprived of their liberty. One person, who staff said lacked capacity, was assisted to bed in the afternoon with the intention of them not being assisted to get up again until the following morning. This person had bed rails in place which meant they would be unable to get out of bed if they chose. Another person was observed trying to leave the unit and was prevented from doing so by staff. We found the location were not meeting the requirements of the Deprivation of Liberty Safeguards.

We looked at the care records in relation to mental capacity assessments for four people and found that the Mental Capacity Act 2005 was not being adhered to. This is an act introduced to protect people who lack capacity to make certain decisions because of illness or disability. The two staff we spoke with had a good understanding of the MCA and described how they supported people to make decisions. However we saw that staff had done assessments of people's capacity to make decisions and

Are services safe?

although questions had been left blank on the assessment forms, staff had stated these people were lacking capacity. It would be difficult to assess a person's capacity properly without completing all of the questions on the assessment. This meant that people's mental capacity was being assessed without following the appropriate guidance for assessment.

All four people had an assessment in place which was designed to assess their capacity to make certain decisions, however these were not decision specific. For example, we saw staff had recorded that one person could not make decisions or communicate choice and so staff needed to make their decisions for them. We saw staff had made the decision, with consent from the person's GP, to give the person their medication covertly (in food and drink without the person's knowledge). The required two stage best interest assessment had not been completed for this decision. Staff had also made the decision that three of these people needed to have bed rails in place to protect them from falls. Again, the required two stage best interest assessment had not been completed for this decision.

A further person was not allowed, by staff, to leave the unit they were living in despite us observing them trying to leave. We asked if a Mental Capacity Act assessment was in place for this decision and staff told us it was. However when we asked to see the written information we found that a capacity assessment had been completed but that it was not for this specific decision. This meant people who lacked the capacity to make certain decisions were not being protected from the Mental Capacity Act safeguards.

We found that Do Not Attempt resuscitation forms had been completed for the seven people whose files we looked at. However not all of the questions on the form had been answered for three of the people. For example: Had 'the decision been discussed with the patient or other members of the health care team' and no explanation as to why it had not been completed was recorded on the form.

This meant there had been a breach of the relevant legal regulation (Regulation 18 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

Are services effective?

(for example, treatment is effective)

Our findings

When we inspected the service in August 2013, we asked the provider to make improvements to the training staff were given and to the supervision they received. The provider sent us an action plan as requested, telling us when they would make the required improvements. We checked to see if these had been made during this visit and we found that they had. Further training had been given to staff and supervision sessions were taking place.

The manager told us that no-one who lived in the home was currently using an advocate. They told us they did not have any information in the home informing people how they could access an advocate if required. Advocates are trained professionals who support, enable and empower people to speak up. This meant people may not be aware of advocacy services which are available to them.

We found conflicting evidence across the home in relation to how people's health care needs were assessed, planned for and delivered. Records showed that people had access to health care professionals such as GPs, physiotherapists, chiropodists, opticians and dentists on a regular basis.

The care plans included the information about what name people preferred to be known by and we saw this was followed in practice. Risk assessment for pressure care, falls, personal safety and mobility and nutrition were in place and had been regularly reviewed. There were care plans in place for the assessed risks, informing staff how to support people and minimise the risks. However we found staff were not following these in a consistent way. For example, we saw one person who was at risk of developing a pressure ulcer and their care plan stated they needed a pressure relieving mattress and to be supported to reposition four hourly to minimise the risk of them developing a pressure ulcer. This person's pressure relieving mattress was on an automatic setting, self-adjusted to the person's weight and the repositioning chart demonstrated regular and timely repositioning. However a further person who had been assessed as being at 'high risk' of developing a pressure ulcer did not have any records in place showing that staff were supporting them to reposition, despite the nurse telling us staff should be giving this support.

We saw another person had a pressure ulcer and their care plan stated they needed to be supported to reposition

every four hours. We looked at the records staff kept for this person's repositioning and the records reflected that there were gaps of up to seven hours between the times the person was being supported to reposition. This person also had a pressure relieving mattress but we found it was on the wrong setting for the person's weight and so might not have been effective in helping the pressure ulcer to heal or preventing further pressure ulcers. Staff were completing regular checks on people's pressure mattresses but there was some confusion as to what the settings should be. We saw that the nurses had assessed the ulcer as being a 'grade two ulcer. However from the information they had recorded, it was clear this was a grade three ulcer. The nurse we spoke with agreed this information needed updating to reflect the correct information. This meant this person's wound was not being treated appropriately and staff were placing them at risk of developing further pressure ulcers.

The care plan/risk assessment for one person who had epilepsy stated, 'If the seizure continues 10-15 minutes after diazepam administration...' but there was no further information about what action staff should take if this should occur. This care plan/risk assessment had been written in July 2013 and reviewed monthly but no one had noticed that the information was missing. This meant this person was at risk if they did have a seizure.

We observed two members of staff unsuccessfully trying to assist one person up from their chair five times by locking their arms behind them and trying to encourage them to stand up. When we looked at the person's moving and handling risk assessment, it stated that they did not need staff or any equipment to help them stand up. This had not been reviewed to show the level of assistance that was needed and demonstrated that people's care was not always being assessed to make sure staff had the right information to support them. We observed a further person being transferred by two members of staff. Staff used a 'stand aid' for this person to mobilise them and this equipment should only be used when the person is able to weight bear. We observed that this person did not weight bear during this transfer and so they were being held up by the stand aid sling. This form of transfer is not good practice and is referred to as a, 'mechanical drag lift.'

Are services effective?

(for example, treatment is effective)

This meant there had been a breach of the relevant legal regulation (Regulation 9 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

People were not always protected from the risks of inadequate nutrition and dehydration. We saw one person had been assessed as being at risk nutritionally and staff had made the appropriate referrals and put a care plan in place to support this person with their nutrition. However we saw another person had been steadily losing weight since admission to the home. A dietician referral was not requested for 10 months, despite the person having lost 10 kilograms by that time. The provider's policy was to refer people to the dietician if they reach a score of three on the Malnutrition Universal Screening Tool (MUST), a nationally recognised tool for assessing people's risk of malnutrition.

This person had scored a three on the MUST for three months before the referral was made. We saw the dietician had given specific instructions for staff to follow to try and prevent this person from losing more weight. However these instructions were different to what had been recorded in the person's care plan and food charts did not reflect the person was receiving the nutrition recommended by the dietician. The person's food intake records did not always make it clear how much they had eaten and we saw staff had sometimes recorded 'biscuits' when the person was supposed to be on a soft diet. This meant people were not being supported to safely maintain their nutrition.

We saw a further person had lost weight and a referral had been made to the dietician, who had made recommendations for staff to follow. This had resulted in the person gaining some weight and the dietician had then discharged them from the dietetic service, informing staff to contact them in the future if there were further issues. Staff had stopped monitoring the person's food intake and we saw this person had started losing weight since they had been discharged. However staff had not made contact with the dietician to seek advice, in line with their recommendation. When we pointed this out to the nurse they told us they would make the referral that day. This meant people were not always protected from the risks of inadequate nutrition.

One person's care plan stated that the GP had advised them that they should be on a low potassium diet. There was then an entry stating that the person's family had

decided that that they shouldn't be on a low potassium diet. We asked the nurse in charge of the unit what information the staff should be following and she stated that they were providing a low potassium diet and agreed that the care plan was confusing for staff. This meant there was a risk the person may not get the diet that had been recommended for them.

We saw that three people needed to have their fluid intake monitored and staff recorded what they drank each day. However the recommended amount each person should be drinking (according to their weight) was not recorded and records showed that two people sometimes consumed very little fluid. There was nothing recorded to show if these people had enough fluids to keep them healthy or what action had been taken when records showed only a small amount had been consumed on certain days. There was nothing recorded from 5pm until 8am on the records of one person over the period of a week so it was unclear whether they had been given a drink during these times. This meant people were not always supported with their hydration.

This meant there had been a breach of the relevant legal regulation (Regulation 14 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

During lunch we saw there were two options of meal. On one unit of the home, we saw one member of staff ask a person who was refusing to eat, what their favourite food was so that it could be made for them. We also saw the person was offered "finger foods" later in the day which they ate. A further person refused their dessert and staff tried to tempt them with an alternative. A relative told us they felt the food could sometimes be better but that if their relative refused the meal, an alternative would be given. This meant people on this unit were given a choice of what to eat.

On one unit we observed some people chose to eat in the dining room, and those that needed assistance were being given the time and help they needed to get to the dining room. Some people chose to eat in their rooms and we saw that staff respected this decision. This meant people were given choices about where they ate.

The food we saw served at lunch did not look appetising due to a lack of colour; everything on the plate was white. The meal consisted of meat in a white sauce, mashed potato and cauliflower with rice pudding served for

Are services effective?

(for example, treatment is effective)

dessert. However the manager said this must have been an oversight and it would be looked at. With the exception of one person, all of the people we spoke with commented positively on the food served. One person said, "The food is good, there is always a lot of choice. The fruit salad is particularly excellent, at least six really fresh fruits. I have put on weight since I have been here." Another person said they were, "impressed with the food and the choice. Delicious." One person we spoke with said, "The food is good and there is plenty of choice, but often when meals were served to me in my room they are cold."

One person's care plan included information on how the person used facial expression and gestures to communicate. The daily notes for the person showed that staff had noticed that the person had a mouth ulcer as they 'seemed' to be in pain when eating and had arranged for the necessary medication. This meant staff responded to the changing needs of the person.

All of the people who lived in the home and their relatives we spoke with told us they knew about their care plan and had been involved in either a review or the setting up of the plan. People told us they knew staff kept records about them such as what they ate and drank. This meant people could express their views about the assessment of their needs.

We saw one person with complex health needs had been referred to several specialists when their health needs changed. We saw staff were delivering care and support to this person in line with the advice given by these specialists. This meant staff had responded to this person when their health needs changed.

Are services caring?

Our findings

We received some positive comments about the staff and the care people received. One person told us, staff were, “Marvellous.” Another person said, “Staff are kind and compassionate, the girls are marvellous, very respectful, I never feel embarrassed, I think the world of them.” Another person said, “I don’t like accepting personal care from anyone, but under the circumstances staff make it the best it can be. They couldn’t do more to put me at my ease and they always make sure the door and the curtains are tight shut.”

One relative told us they were very pleased and since their relative had moved into the home they were, “much happier now, a real improvement.” Another relative said that when their family member had moved in they had had some difficulty settling in and had become quite frustrated. They had discussed this with the assistant manager and said the assistant manager had then spent time with their family member to help them to settle. A further relative said, “[Relative] always looks well groomed and the family couldn’t be happier with the care.” Another relative said, “Staff could not be kinder.”

People told us they felt their privacy and dignity were respected. One person said, “The staff give personal care very discreetly, I always feel my privacy and dignity are respected.” This person was able to give us an example of what staff had done to alleviate their embarrassment in relation to personal care.

Staff had been trained in how to respect people’s privacy and dignity and the staff we spoke with had an understanding of how they needed to put this into practice. Throughout our inspection, we saw staff respecting privacy and dignity when supporting people with personal care and by knocking on doors prior to entering bedrooms. This meant staff knew how to treat people with respect and observe their privacy. We did see that some people living on the unit designed for people with a dementia related illness had their names on the front of their slippers and socks. Although items need to be named to ensure the right person had them this was not dignified for these people as the names were very prominent.

However our observations did not always support what people had said to us. Observations on one unit showed that the care was mostly task based and that staff did not

always focus on people as individuals. For example, one person asked for a cake and was given one but then was left repeatedly asking for help to pick it up until a carer heard them and responded. Another person had been left with their medicines and they were distressed. They said they didn’t know if they should take the medication as the nurse had said not to, but had not returned. We found the nurse and they told us they had forgotten to return to the person. This meant the actions of the nurse had caused distress to this person.

We observed one member of staff ask someone if they would like assistance with a shave and they confirmed that they would so the member of staff stated that they would help them after dinner. In the afternoon we saw the same person crying and as no other staff were in the lounge we asked them why they were upset. They told us they were upset because they could no longer shave themselves and it made them feel dirty and no one had helped them with a shave that day. We found a member of staff who told us they had forgotten to go back and assist the person with shaving and the person could not have a shave at that point as their razor was not charged.

We did see some good interaction between staff and people who lived in the home such as one member of staff singing with someone. However some observations showed a lack of interaction with people who lived in the home so there were missed opportunities for communicating with people and those people who remained quiet got very little attention from the staff.

The care plans we looked at were mostly health and risk based. The plans told staff very little about people’s preferences or personal history. We saw one care plan where staff had added a document called, ‘All about me’ and this gave staff more information about this person. However the rest of the care plans were not person centred and only contained sparse reference to the person as an individual. This meant staff did not have the information relating to people’s life and history so they could support them in a more individualised way.

We looked at the care records of one person who was receiving palliative care. There were plans in place for staff to follow when the person reached the stage where they would need end of life care. This meant the person would be supported to remain in the home and comfortable at the end of their life.

Are services caring?

We saw from other care plans that staff had recorded people's preferences for when they reached the end of their life. One person had a funeral plan and a copy of this was

retained in their care plan to make sure staff had the relevant information when their death approached. This meant people's choices in relation to the end of their life were recorded and planned for.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We looked at the complaints records and we saw there was a clear procedure for staff to follow should a concern be raised. There had been nine complaints raised by people living in the home or by their relatives. Records showed these had been investigated and responded to by the manager, in line with the complaints procedure. Staff we spoke with knew how to respond to complaints if they arose including how to assess if referrals to the local authority needed to be made.

One person told us, "I have been given very little information and do not know who to speak to with regards complaints." Another person told us, "Information is very limited and I would not have a clue about how to make a complaint, or who to make it to." One relative told us they had raised a concern and that the manager had addressed the issue straight away. This meant that when people did make a complaint, these were responded to and dealt with in line with the home's complaint procedure. However not everyone knew who to speak with if they wanted to make a complaint.

People we spoke with confirmed that they were able to make everyday choices, and relatives of people with a dementia related illness said that this was also the case and that their family member's choices were respected. However our observations did not support that people were always given choices.

During the morning we observed the "tea round" on one unit. Although six people were given a drink, no one was offered a choice: they were all given tea apart from one person who was given juice. However when we looked at the care plans for two people, one of them stated that the person preferred cold drinks but they were given a cup of tea. The care plan for the person, who was given juice, stated that they preferred a cup of tea.

One person asked for a biscuit and when they complained that it was too hard they were told there wasn't any softer ones so to, "nibble it slowly." We observed one person saying that the tea wasn't sweet enough but they were not offered any more sugar. We also observed the same person at lunchtime asking for a tea with more sugar but this was again not recognised by the staff. This meant the person was not being supported to make choices.

During our observations on one unit we saw that people with a dementia related illness were not supported to make choices about what they ate. People had chosen their meal the day before and one person said they could not remember what they had ordered. There was no visual aids to assist people in choosing their meal.

Although there was a timetable of activities posted on the noticeboards and on the day of our visit one unit had a karaoke session, all of the people we spoke with said either that they were unaware of any activities or that there was, "not much going on." One person said, "There is nothing to do." Another person said, "There is nothing to do, there are grounds outside, but you can't go out, the door is locked. I have said that I would like to go out in the garden, but the answer was no. I am never asked for my opinion on what I would like to do. I don't like sitting indoors and staring at these four walls all the time." One relative told us they felt there was not enough for people to do and said that a carer had recently done an activity with their family member and they had really enjoyed it. They told us that this was the first and only time they had been able to engage in an activity like that. Another relative said they didn't know about any activities apart from a recent 'sing-a-long' which their family member could not participate in as they had a hearing impairment. We received comments such as this from people on all of the four units of the home.

One person, who had a dementia related illness, received close supervision from staff for most of the day, in line with their planned care. We observed this person spent much of the day walking around the home and although staff walked with them, holding their hand, they were not engaging with them or listening to what they had to say. There were no attempts to get the person involved in any meaningful activity. Discussions with the manager showed that staff had not attempted to introduce activity which would be meaningful for this person. For instance, we found out they liked gardening and had spent much of their life running a busy household. This meant people's life histories were not being used to form a part of how they spent their day.

We raised concerns with the manager and a member of staff in relation to the number of people who were assisted into bed after lunch. We looked in the care plan for two of these people who had been assisted into nightwear and into bed at 2.30 in the afternoon and there was no rationale for them being in bed recorded in their plan. Both of them

Are services responsive to people's needs?

(for example, to feedback?)

had bedrails on the bed and so were unable to leave the bed and neither had a radio or television on. Both were awake and alert and we had concerns about the social isolation for these people. No valid reason for these people being in bed so early in the day was offered to us when we asked. A member of staff said that one of these people

tended to slip out of their chair and so was safer in bed. There was no evidence this person had been referred to an occupational therapist to see if a specialist chair was needed. This meant some people were being placed at risk of social isolation.

Are services well-led?

Our findings

When we inspected the service in August 2013, we found concerns in relation to the systems in place to assess and monitor the quality of the service. We asked the provider to send us an action plan and tell us what they would do to make improvements. When we visited the home this time, we found that there had been some improvements in some areas but the systems for monitoring the quality of the service were still not effective.

Prior to this visit we asked health and social care professionals for their opinion of the service. We were told that there had been some concerns about staffing levels in the home. We spoke with the manager who could not explain how current staffing levels had been determined and if there were adequate numbers of staff to meet people's needs. Our observations and discussions with people gave us evidence that there were not sufficient numbers of suitably experienced and skilled staff to meet the needs of the people living in the home.

We spoke with six people who lived in the home and four relatives over all units and all of them told us they felt there should be more staff. One person told us, "They [staff] often do not come quickly enough when I ring the bell and I get so desperate I end up having to urinate into my pads." This person told us they had needed assistance from staff in the middle of the night but despite ringing their bell, had been 'left in my own mess' for two to three hours. On other occasions this person told us they been left sitting on the commode for long periods of time. Both this person and their visitor said that they believed there were not enough staff, "Even on a quiet day." The relative told us, "They simply cannot cope. Every time my relative rings their bell, they are asked [by staff], 'Can it wait?' This is because staff are busy attending to someone else, and at least 15 minutes goes by before someone comes back."

Five other people who lived in the home raised concerns about the levels of staff. Two people said, the home "Could do with more staff." One person said, "There are not enough staff. If you ring the bell, they will come after a while and they apologise for the delay, saying 'Sorry, we are very busy.'" In particular, the night staff look absolutely exhausted." Another person told us they were supposed to be supported with practising being up on their feet and walking again after their accident, but that whenever they asked for this supervision they were told, "staff are 'too

busy." A further person told us, "Staff promise to do or fetch things but rarely remembered. Because of the shortage of staff, carers are rushed and do not have time for the 'niceties' and so are more task orientated than person centred. Nobody chats to you, they are finishing off their sentence as they walk out the door; this place is desperately understaffed. I realise that in general, they are not being disrespectful, just overworked." The fifth person said, "There is not enough of them [staff], and so they cannot spend a lot of time with residents."

We observed there were some people in one area of the home who were not able to move from their bedroom without staff assistance. We did not see them being checked on by staff whilst we were in that area, over the period of a couple of hours. One person who was in their bedroom said, "There are not enough staff, I spend a lot of time in my room and you hardly see anyone." We asked another person who spent a lot of time in their room how often staff checked on them and they said, "Hardly at all."

One relative told us they felt that more staff were needed, particularly with regards to activities and that their relative needed more stimulation. Another relative said, "There could be more staff on duty. They do look in on [my relative] when they can."

We observed lunch and on one unit we saw one person had to wait for an hour in the dining room before they were given any food as they needed a member of staff to assist them and staff were all busy assisting other people. We saw that although people had finished their main course they had to wait at least 30 minutes for their dessert as there were no clean bowls and the staff were told they would have to wait until some were returned to the kitchen and washed up. This meant people had to wait for unacceptable periods of time due to a lack of leadership over the meal period.

This meant there had been a breach of the relevant legal regulation (Regulation 22 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

We spoke with people about how well led they thought the home was and if they knew who the overall manager was. One person told us, "As far as I can make out, there is no proper structure of command; I have no idea who is in charge or what people's roles are." One person said, "I know who the unit manager is, but not the overall manager."

Are services well-led?

Another person told us they had not met the manager but said, “The unit have made an effort to get to know me. They are all very friendly.” One relative commented positively on the assistant manager and said, “They are very approachable,..... really listens to what you’ve got to say.” This meant that people who lived in the home did not have a clear idea of the structure of the management team.

We saw evidence that the provider’s quality team completed monthly visits at the home. These visits were to assess the quality of the service by way of completing audits of the systems in place. The manager told us these were used to improve the quality of the service. We saw there were also audits taking place in the home in relation to infection control, medication and care plans. However we found evidence of concerns in all of these areas, which meant the systems in place for monitoring the quality of the service were not effective in identifying concerns and improving the service.

We observed in two of the units that there was a lack of space when people were sitting in dining areas for lunch. On both units we observed people and/or furniture had to be moved around during the meal to allow for people to get up and down from their seating. On one unit staff had to wait for a person to move out of the dining room so they could move a table and make room to assist another person to eat. This did not create a relaxed environment for people to enjoy their meal and it had not been recognised by the management team despite us hearing staff say that there was not enough room in the dining rooms.

This meant there had been a breach of the relevant legal regulation (Regulation 10 of the Health and Social Care Act 2010) and the action we have asked the provider to take can be found at the back of this report.

We spoke to the manager and regional manager in relation to the concerns we found at the home during our visit. They told us the regional manager was new in post and was committed to supporting the manager to make improvements in The Cambridge Nursing Centre. They told us there were plans to introduce a tool to assess the staffing levels in the home.

We saw the manager had implemented a ‘take 10’ meeting each day. This involved the manager, nurses and other lead staff meeting up to discuss issues in the home, risks, changes to people’s health and actions for the day. There were also regular meetings held between staff at all levels in the organisation. This meant information was shared between management and staff to promote an inclusive environment and have transparent methods of communication.

We spoke with a recently recruited nurse in the home, who was also the unit manager and they told us they had received an induction when they first commenced working at the home. They told us they had support when they needed it. Three care workers we spoke with also told us they had received more training in the last six months. They said they felt the management team were supportive and approachable. All three members of staff said they would feel confident challenging and reporting poor practice and that they felt this would be taken seriously. Records we saw confirmed recent training had been given to staff in relation to a wide range of subjects including, health and safety, safeguarding vulnerable adults, role of the health and social care worker, communication, equality and inclusion, person centred support, nutrition and hydration and the Mental Capacity Act 2005. We saw that some nurses and care staff had also been given recent training in subjects such as pressure ulcers and medication management. This meant the provider had improved the frequency of the training and supervision given to staff.

We spoke with the manager about any improvements which had been made or were planned for the home. They told us there had been some redecoration and restructuring in the unit of the home designed for people living with a dementia related illness. They told us the next phase for this unit was to make the lounge area more homely and to train staff in how to support people with dementia related illnesses.

We saw there were plans in place for emergency situations such as an outbreak of fire. Staff understood their role in relation to these plans and had been trained to deal with them.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 (1)(a)(b)(i)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and welfare of people who use services The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 (1)((a)(b)(2)(v) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. The registered person did not have effective systems in place to monitor the quality of the service delivery.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Safeguarding people who use services from abuse The registered person did not have suitable arrangements in place to protect service users from all forms of abuse.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of medicines

This section is primarily information for the provider

Compliance actions

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 14 (1)(a)c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Meeting nutritional needs.

The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing

The registered person did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experienced persons employed.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Cleanliness and infection control The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection.