Hestia Healthcare Limited

The Willows Residential and Nursing Home

Inspection report

73 Shakespeare Road
Bedford
Bedfordshire
MK40 2DW

Tel: 01234268270
Website: www.kingsleyhealthcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Willows Residential and Nursing Home provides a service for up to 32 people, who may have a range of care needs including dementia and physical disabilities. There were 32 people using the service at the time of this inspection, of whom 27 were living with dementia and seven were being cared for in bed.

We carried out an unannounced comprehensive inspection of this service on 29 January 2015 and found legal requirements had been breached in a number of areas such as staffing, staff training, complaints, meaningful activities and the leadership of the home. However, the provider was able to demonstrate that they had identified these issues before our inspection and showed us that they had appropriate plans in place to address them. Therefore, we did not impose any enforcement actions on the provider at that time. During this inspection, we found that improvements had been made in some of these areas, but not all. Furthermore, new concerns were identified.

Shortly before the inspection we were informed that the registered manager was due to leave and a new manager had been appointed. The new manager had not yet applied to register, but told us they planned to do so. 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.

This inspection took place on 21 January 2016 and was unannounced.

We found that processes in place to manage individual risks were not sufficiently robust.

Arrangements to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff; in order to be able to meet people's needs, were not adequate.

Systems were in place to ensure people's daily medicines were managed in a safe way and that they got their medication when they needed it. However, these were not consistently followed.

Staff received training to carry out their roles and responsibilities, but because of a high turnover in staff, there were some gaps in training.

There were inconsistencies in the way people's nutritional needs and preferences were being met.

People were supported to maintain good health and have access to relevant healthcare services, but they did not feel adequately involved in decisions about their own healthcare.

People were not consistently treated with dignity and respect.

The staff were mostly kind and caring, but there were missed opportunities for meaningful engagement with people.

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

People's social needs were not adequately provided for, and meaningful activities were not in place for people living with dementia.

There were ineffective management and leadership arrangements in place.

The systems in place to monitor the quality of the service provided and drive continuous improvement were not always effective.

We found improvements with the maintenance of staff training records. There was evidence that staff had been trained to recognise signs of potential abuse and keep people safe.

The provider carried out recruitment checks on new staff to make sure they were suitable to work at the service.

The service worked to the Mental Capacity Act 2005 key principles.

Systems were in place for people to raise concerns or make a complaint if they needed to do so. We noted that records relating to complaints had improved and provided a clear audit trail of any actions taken in response.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Staff understood how to protect people from avoidable harm and abuse.

However, processes in place to manage risks were not sufficiently robust.

Arrangements to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff; in order to be able to meet people's needs, were not adequate.

Systems were in place to ensure people's daily medicines were managed in a safe way and that they got their medication when they needed it. However, these were not consistently followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training to carry out their roles and responsibilities, but because of a high turnover in staff, there were some gaps in training.

There were inconsistencies in the way people's nutritional needs and preferences were being met.

People were supported to maintain good health and have access to relevant healthcare services, but they did not feel adequately involved in decisions about their own healthcare.

The service worked to the Mental Capacity Act 2005 key principles.

Is the service caring?

Requires Improvement

The service was not always caring

People were not consistently treated with dignity and respect.

The staff were mostly kind and caring, but there were missed

opportunities for meaningful engagement with people.

There were opportunities for people to be involved in planning their own care.

Is the service responsive?

Requires Improvement

The service was not always responsive

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

People's social needs were not adequately provided for, and meaningful activities were not in place for people living with dementia.

Systems were in place for people to make a complaint, if they needed to do so.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were ineffective management and leadership arrangements in place.

The systems in place to monitor the quality of the service provided and drive continuous improvement were not always effective.

The Willows Residential and Nursing Home

Detailed findings

Background to this inspection

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

The inspection was unannounced and was carried out on 21 January 2016 by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law. In addition, we asked for feedback from the local authority and clinical commissioning group, who both have a quality monitoring and commissioning role with the service.

During the inspection we used different methods to help us understand the experiences of people using the service, because some people had complex needs which meant they were not able to talk to us about their experiences.

We spoke with six people living in the home and observed the care being provided to a number of other people at key points of the day including lunch time. We also spoke with the registered manager – who was due to leave the following week, the new manager, new deputy manager, the director of nursing and clinical services, the nursing manager, one nurse, two care members of staff, the home's administrator, the cook, a social care student and four relatives.

We then looked at care records for six people, as well as other records relating to the running of the service such as: staff records, medication records, audits and meeting minutes; to corroborate our findings, and to

check whether or not the required improvements had been made.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in January 2015, we found some areas that required improvement. For example, evidence of safeguarding training for staff, consistency of pressure care mattress checks and staff phoning in sick, placing other members of staff under pressure to keep people safe and meet their needs. The provider was able to demonstrate that they had identified these issues before that inspection and had appropriate plans in place to address them. Therefore, we did not impose any enforcement actions on the provider at that time.

During this inspection, we found that improvements had been made in terms of staff training records and the consistency of mattress check timings. However, concerns were still evident regarding staffing, and additional new concerns were also identified:

Risks associated with people's care were not always managed clearly or in a safe way. The home used an electronic system for assessing, planning and recording people's care needs and we saw that individual risks to people, such as malnutrition and skin integrity, had been assessed and reviewed on a regular basis; to ensure the identified risks were being properly managed. Staff told us that additional paper observational charts had recently been introduced; to supplement the electronic records and to support them in recording care provided at the actual time of delivery. They also told us it was the responsibility of senior staff to check the charts, to ensure they were being completed correctly.

Observational charts that we saw were being used to record key areas of care being provided to people including how often they were being repositioned and their food / fluid intake. We looked at charts for people who were at risk of malnutrition or developing a pressure ulcer, and found inconsistencies with the information recorded. Some of the charts provided good detail and had been completed at the time of care being provided, but others had not.

At 13:45 hours we checked one person's observational charts. They had not been updated since 07:00 hours for some aspects of their care. The person was being cared for in bed and was not able to talk to us to tell us about the care they had received. The chart recorded that the person's continence pad had not been changed since 07:00 hours. However, additional electronic records for the same person stated that they had had their pad changed at 07:40 hours. This showed that paper and electronic records did not match, and meant we could not be clear as to when they had had their pad changed. There was also no record of their pad being changed since.

We then checked to see when the person had last eaten or drank. Their observational chart recorded that they had been offered drinks up until 12:00 noon, but there was nothing to indicate that they had been given anything to eat since breakfast at 08:00 hours. We checked on another person at 14:00 hours. Their observational chart stated that they had eaten some breakfast, but lunch had also not been recorded on their charts. In this room, we saw bowls containing food; indicating that they had eaten, but staff had not updated the records. This meant that people were being placed at possible risk of harm, because records designed to record key areas of their care did not adequately demonstrate the care provided to manage

identified risks.

At lunch time we saw one person being given apple crumble to eat. They were then heard choking. A senior member of staff told us afterwards that the person needed assistance to eat, but this had not happened. We checked the person's records which stated their food needed cutting into small pieces, but this had also not happened. Although they did not come to harm on this occasion, this demonstrated that arrangements for managing identified risks were not always followed.

We observed a member of staff supporting one person to walk by holding onto the top of their trousers, which were doubled over at the waist band. The person appeared unsteady at this point and was also seen leaning their head on the staff member's shoulder. Later, we saw a different staff member supporting the same person to walk by placing their arm around their waist. They did not did not hold onto the person's clothing. This demonstrated discrepancies in the way that the person was supported to mobilise. The registered manager told us the person was independently mobile so did not currently require specific guidance to support them with their mobility. However, it was clear from our observations during the day that the person actively sought physical contact from the staff team to mobilise. This meant that without proper guidelines in place to help staff provide support in a safe and consistent way, the person and staff may be at risk of possible harm or injury.

We also found that medication was not always given in a safe way. For example, we observed a nurse signing medication administration records (MAR) before they administered insulin to one person. The nurse was able to demonstrate a good understanding of diabetes, including the risks associated with low and high blood sugar levels. However, we were concerned that if the nurse then forgot to administer the insulin, there was a risk of the person developing high blood glucose, or worse.

These were breaches of Regulation 12 (1) (2) (b) (e) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection we had received information of concern about staffing levels. We raised this with the provider and they responded quickly with clear information about how staffing levels were calculated. We looked at staff rotas during this inspection and saw that staff were planned according to the information provided previously to us. There were six care staff and two nurses on duty in the morning, six care staff and one nurse in the afternoon and three care staff and one nurse at night. Additional support was provided on the day of the inspection from the registered manager, the new manager, a new deputy manager, the administrator, the chef, two domestic staff, the activity lead, the maintenance lead and a health care student from a local college, who was working at the home one day a week.

Despite the numbers of staff on duty, people told us they didn't always feel the staff had the right skills and knowledge to meet their needs. For example, one person with a catheter said they were concerned that not all staff knew how to deal with it properly, as it often leaked onto the floor. People also told us their call bells were not always answered in a timely way. They told us when staff were busy they would turn off their call bells and tell them they would be back in five minutes. One person told us: "Sometimes [the wait] can be a very long time. Another person added: "Fridays and the weekends are worst for response to the call bells." A third person told us: "I have had accidents before in the lounge because they take so long to come to me – even when I have asked." We observed an occasion when it took staff 11 minutes to take someone to the toilet, despite the person making it very clear that they urgently needed to go. At one point the person was asked to wait until two staff became available; because they needed two staff to safely hoist them into a wheelchair. This demonstrated that staff were not available in sufficient numbers, in order to meet peoples' needs.

Relatives echoed people's comments. One relative said: [The person] has complained about the amount of time it takes them to come to [them] at night and at the weekends." Another relative told us: "[The person] often has their lunch late because [the person] has not had their morning care – they [the staff] come around 12.00 noon – 12.30pm." We spoke to a person during the inspection who confirmed they had not had their morning wash until 12 00 noon, and had been given their lunch late as a result.

All of the staff we spoke with said they felt that there were enough staff on duty. However, they told us they had to balance their work between monitoring people in their rooms and looking after people in the communal areas. They said that sometimes they were unable to provide people with the care they needed, when they needed it. One member of staff told us: "The bells sometimes go for a very long time. Lots of times we seem to be short staffed." Another staff member said: "We are rarely able to give residents showers or baths when they would like one because we never know how many staff will be on duty." We observed at key times, such as lunch time, that senior staff remained in the office, rather than assisting the care staff with getting people's meals out to them or helping them to eat. We also observed a member of staff taking their break during lunch.

On the day of the inspection rotas showed that two members of staff were off sick, but they had been replaced by permanent staff rather than agency staff. A member of staff told us: "We are often short staffed – the rotas are written fine but then staff don't come in." They confirmed they were able to phone agency staff as required, but when staff phoned in sick at the last minute, it made it very difficult to get adequate cover. The management team advised that there had been some issues with staffing, as two staff were currently off sick and two were on maternity leave. However, we were told that two new bank staff had been recruited, and the provider was in the process of carrying out checks to ensure they were suitable to work at the home.

Findings from this inspection have shown that improvements were still required in this area. The arrangements to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff; in order to be able to meet people's needs, were not adequate.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they felt safe in the home. One person said: "I feel safe here. It's a nice place." A relative added: "Yes, we were very worried about him when he was in hospital but not since he has been here." Staff told us they believed people using the were safe in the home. They all reported that they had never seen or heard anyone spoken to in an inappropriate manner. They told us they would intervene if they heard this happening and we saw this happen during the inspection. They also told us they would report any concerns immediately to the manager.

Staff confirmed they had been trained to recognise signs of potential abuse and knew how to keep people safe. Training records we looked at supported this for the majority of staff, and the new manager confirmed she had a plan in place to ensure all members of staff had completed this training in the following two weeks.

Information was on display which contained clear information about safeguarding, and who to contact in the event of suspected abuse. Other records showed that the service followed locally agreed safeguarding protocols and reported potential safeguarding matters to the relevant authorities and agencies.

The management team and maintenance lead spoke to us about the arrangements for making sure the

premises was managed in a way that ensured people's safety. Records showed that systems were in place to ensure the building and equipment was safe and fit for purpose, and that regular checks were carried out. Clear information was also available regarding fire safety and the arrangements to follow in the event of a fire. We were also shown a business continuity plan had been developed. This showed that there were arrangements in place to respond to emergencies or untoward events.

The home's administrator described the processes in place to ensure that safe recruitment practices were being followed; to ensure new staff were suitable to work with people living in the home. They told us that new staff did not take up employment until the appropriate checks such as, proof of identity, references and a satisfactory Disclosure and Barring Service [DBS] certificate had been obtained. We looked at records and found that systems were in place to ensure legally required checks were in place before staff started working in the home.

Systems were in place to ensure people got their medication regularly and when they needed it. Staff demonstrated a clear understanding about medication processes such as administration, management and storage. They told us about the '10 point MAR check' which was carried out at each staff handover; to ensure medication was being given as prescribed. We observed a member of staff administering medication to people at lunch time. They took the time to explain to people what each medicine was for. One person was hesitant to take their medication, and we noted the member of staff provided reassurance and explanations in a patient way. The person was then seen to take their medication in a relaxed manner.

There was evidence that medication stock levels were checked regularly, including controlled drugs. Temperature sensitive medications were also being stored appropriately. Medication administration records (MAR) provided information about medication stock levels and administration, including missed / refused doses or use of PRN (when required) medications. Aside from the insulin which had been signed for in advance, records we looked at were clear and had been completed accurately.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in January 2015, we found some areas that required improvement. For example, people told us their needs, preferences and choices were not always met by staff who had the right skills and knowledge. They were concerned about the turnover rate of staff, which meant that there was a lack of suitably trained staff working at the service. The provider was able to demonstrate that they had identified these issues before our inspection and had appropriate plans in place to address them. Therefore, we did not impose any enforcement actions on the provider at that time.

During this inspection, we found that improvements were still required regarding staff skills and knowledge. In addition new concerns were also identified:

People provided variable comments about the food provided. One person said: "The food is good – I like it. We get a choice every day and a hot pudding." Another person told us: "The food is okay at lunchtime but every evening it's the same." People who chose, or needed to eat in their bedrooms, told us that their food sometimes arrived cold. They also told us they would like more variety.

One person who was being cared for in their bedroom told us they often didn't get a drink in the afternoon, but were offered one with supper, which was not their preference. A relative confirmed they brought milk in to make the person a drink when they visited. They told us that when they asked for a drink it was not always forthcoming. We saw that the relative had brought a pint of milk in, and there was a drinks machine in the person's room. The person was being cared for in bed so would not have been able to make their own drink without assistance.

We asked staff how they ensured people had been given enough to eat and drink. One member of staff told us: "In the residents rooms there are charts to record when they are given a drink and food…I try to ensure that charts are completed. Sometimes there are gaps."

We observed inconsistencies in the way people were provided with choices about what they wanted to eat and drink. At lunch time, we observed one person who did not like the dinner provided, so staff arranged for them to have a sandwich as an alternative. However, we were shown an information folder which was kept in the kitchen; to support staff working in the kitchen to know about people's nutritional requirements and preferences. This stated that the person did not like sandwiches. We also observed a member of staff placing a dessert in front of a person, without first asking them what they wanted to eat. However later, we heard another member of staff giving people a choice of what to eat for tea.

Throughout the inspection, food and drinks were provided at regular intervals although it was not clear from the records we saw how frequently these were provided to people who required assistance with eating and drinking, or who were being cared for in bed. This is because records were not always completed at the time care and support was provided. Some people were totally dependent on staff to meet all their needs, so they were not able to tell us when they last ate or drank.

Records we looked at showed that people's nutritional needs had been assessed to determine their nutritional needs and preferences. We looked at records for one person and found inconsistencies. According to their care plan, the person was supposed to have three nutritional drinks /snacks or a fortified diet each day, but there was no evidence of this happening. When asked, staff were not able to explain why not. There were no current concerns about the person's weight, but there was evidence that they did not always eat the meals provided. Another person, who told us they did not like the nutritional drinks provided, said they were no longer having these, because they had gained some weight. Records we looked at supported this, but this change had not yet been reflected in the kitchen folder, which still recorded the person required a fortified diet.

This demonstrated that people's nutritional and hydration needs were not consistently met in accordance with their preferences and needs.

These were breaches of Regulation 14 (1) (2) (4) (a) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People provided variable comments about whether they received effective care from staff with the right skills and knowledge. One person told us: "I don't really know, but they meet my needs." Another person said: "Most of them, but some new girls aren't [sufficiently skilled]." A third person told us: "Well you never know who you are going to get from day to day…You just get used to someone then off they go and someone else comes along." They told us there had been a high turnover of staff since the last inspection.

Staff reported that they received good training. One member of staff told us: "There is lots of regular training. They are good with training here. Another member of staff told us about some of the training courses they had completed. They said: "The e-learning (electronic learning) system tracks and monitors your training. Management tell me what training I need to go on. We do face to face training from time to time." A training matrix had been developed which provided clear information to enable the registered manager to review staff training and see when updates / refresher training were due. This confirmed that the majority of staff had received training that was relevant to their roles such as: the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), safeguarding, medication, nutrition, wound care and moving and handling. Due to staff turnover, there were gaps on the matrix in key areas such as managing continence, dementia, dignity, swallowing and falls. The new manager acknowledged this and showed us that she had a plan in place to address this by June 2016.

There was evidence that meetings with staff were taking place both individually and as a group; providing opportunities for the staff team to discuss good practice and potential areas for the development of the service.

We asked staff how they gained consent from people to their care. One member of staff told us: "We are trained what to say." Another member of staff said: "The care plan says their likes and dislikes." Although some people did not communicate using words, we observed that they were able to demonstrate their consent clearly through other methods such as actions and physical movement. We observed staff seeking people's consent before undertaking various aspects of care and support during the inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met, and found that they were. We saw evidence of DoLS applications at various stages, depending on how long people had lived at the service.

People gave us mixed comments about how their health care needs were met. One person told us: "We feel well looked after medically – neither of us take tablets or need any care from the nurses or doctors. We saw our own optician and dentist before we came here." However, some people told us that referrals to relevant external health services were not always made when their needs changed. One person said: "No I don't feel they meet my health needs here…you have to fight here to get people to listen to you." Another person said: "They were reluctant to get the doctor out – they wanted me to stay here."

Relatives echoed these comments. They told us about occasions when staff from the home had in their opinion, been reluctant to call on external healthcare professionals for help. One relative told us: "There are some staff here who go above and beyond but not all." They told us that when they had reported a healthcare concern to staff, they had not done anything about it.

We spoke to the management team about some of the concerns raised and they told us that because nursing care was provided at the home, they tried to work with the local complex care team in the first instant. The complex care team comprises of nurses and pharmacists, who work with local care homes to avoid unnecessary hospital admissions and GP call outs. Records showed that regular support was provided by the complex care team. Visits to and from external health care professionals were also recorded by staff, with the outcome of those visits.

Despite this support network being in place, people clearly did not feel adequately involved or supported in terms of how their individual healthcare needs were being met.

Requires Improvement

Is the service caring?

Our findings

People told us they were not consistently treated with dignity and respect. One person told us: "[A member of staff] spoke to me like a five year old…I don't need speaking to like that." Other people reported that agency staff were being used which affected their dignity, particularly having lots of different people providing them with personal care. One person told us: "Only some of them [the staff] however, respect your privacy. Not a lot of continuity of care goes on. When it's personal care you like to know your carers, but they come and go here."

Relatives told us they got upset about the lack of positive staff interactions with people when they were assisting them to eat. One relative told us: "He seems to like the food but they don't interact with him when they are feeding him – it's not good enough." At lunch time, we observed staff assisting people in a task orientated way. They stood up whilst providing assistance, or where they did sit alongside people, there were few verbal exchanges. This meant there were missed opportunities for meaningful engagement with people.

On our arrival, one person asked for the toilet. It took 11 minutes for staff to meet this request. Some staff provided verbal responses to the person during this time; to inform them they needed to wait for a hoist to become available and two staff to operate this. Other staff were seen walking past and ignoring the person. Another member of staff brought the person a drink, which caused the person to become even more anxious. We heard them say: "I can't drink anymore – I need to go to the toilet." After 11 minutes, staff took the person to the toilet, but they were wet by this time and were visibly distressed and embarrassed. Staff interactions with the person were limited during this time, and we noted they provided no apology or reassurance to alleviate the person's discomfort and embarrassment. This meant that the person had been placed in an unacceptable and undignified situation. Staff confirmed there was only one working standing hoist at the time of the inspection, and up to three people needed to use this to support them with their mobility.

Other dignity concerns were noted too. Although people's clothes were protected through the use of serviettes, we saw food / drink being spilt down their faces and fronts as a result of staff standing up or putting too much food on the spoon. We then saw a member of staff administer insulin into someone's leg whilst they were in the dining room, surrounded by people. They did not give the person the option of going somewhere more private. We also heard a staff member speaking in a disrespectful way when a person didn't want to eat their dinner. The staff member said: "I don't think it would matter what we offer her to eat, she won't eat it." They said this in front of the person and other people who were in the same room. This demonstrated that people's privacy and dignity was not always considered or upheld.

These were breaches of Regulation 10 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite our findings regarding dignity and respect, people did tell us that the majority of staff treated them with kindness and compassion. One person said: "They are kind and patient girls – basically they are all

okay." Another person said: "They all seem very good and kind, we have no complaints here."

We read some recent feedback from relatives of people. One person had written: 'I would like to thank you all so much for looking after him with such kindness and care.' Another relative stated: 'I have been absolutely overjoyed at the care [the person] has received…The staff all communicate with him using appropriate language and tone. They all have a CAN DO attitude and this has put my mind at rest immensely'.

We observed some kind interactions during the inspection. For example a member of staff was heard to say: "Hello my dear" in a cheery manner, when they brought someone their lunch. We noted too that the health care student made the time to sit and talk with someone living in the home.

People confirmed they were given opportunities to be involved in making decisions about their care, treatment and support. For example one person told us about a meeting they had been part of which had been held to review their care needs, and ensure the care being provided to them was still appropriate. Relatives we spoke with were also able to describe some involvement in terms of planning their relative's care.

During the inspection, we observed occasions when staff explained to people what they were doing and encouraged them to make their own choices as far as possible. For example, people were given choices about what they would like to eat and how they wanted to spend their time.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in January 2015, we found some areas that required improvement. For example, there was no clear audit trail of complaints received by the home. There was also a lack of meaningful and suitable activities for people, including those living with dementia. The provider was able to demonstrate that they had identified these issues before our inspection and had appropriate plans in place to address them. Therefore, we did not impose any enforcement actions on the provider at that time.

During this inspection, we found that improvements had been made in terms of how complaints were dealt with, but not in respect of meaningful activities for people.

People told us the care they received was not always person centred. Some people told us they felt lonely or isolated. This included people being cared for in bed, as well as those who were able to access the communal areas of the home. Some people told us they had just not connected with anyone else living in the home as most people were living with dementia. Some people told us they relied on their visitors, or other people's visitors, for conversation and company. A relative echoed these concerns by telling us: "We worry that [they are] isolated." Observations throughout our inspection confirmed that people were often left sitting in communal areas, without staff support or interaction. People who were dependent on staff to mobilise only moved when going to the toilet, or getting up for meals. This demonstrated that people were at risk of social isolation.

Some relatives told us they did not feel consistently able to contribute to the assessment and planning of their relative's care. This is because they did not always feel welcome when they came to the home. For example, they told us they were not always offered a drink. They also told us they felt discouraged from asking about their relatives. One relative said: "Sometimes I feel the staff are a bit difficult with me. It is quite difficult to get information from them. They always claim to not know anything about what we are asking about – defensive. For example they say – the night staff deal with this…and the day staff know about that… We go round in circles without any answers."

At the last inspection there was little evidence of meaningful activities and people were seen sat around with televisions on, but disengaged. This was the same on this occasion. An activity person was on duty but we noted that they were also providing personal care to people when they needed it; which reduced the amount of time they were able to spend with people.

One person was asked if they would like to play dominoes or look at a book. When they replied neither, the staff member moved on to talk to someone else, rather than explore other options and find something that the person might have liked to do. We observed other people being given picture books to look at, but staff did not take the time to go through these with people.

We heard music playing in someone's bedroom that had been popular in 2003. We asked staff if the person enjoyed listening to this and were told that the person's relative provided music for them to listen to. We checked the person's care records and found they did enjoy listening to music and the radio, but no further

information was provided, such as the type of music the person liked to listen to. We were therefore unsure whether this was to the persons' own tastes or their choice. The person was being cared for in bed so would not have been able to change the music without staff assistance.

We saw that each person had a 'This is me (Life Story)' record, which aimed to provide information about their life and interests, before they came to live at the home. The records varied in detail, depending on how much information staff had been able to obtain from people and their relatives. For example we saw blank spaces for key areas such as: 'Things that worry or upset me', 'Things that give me comfort and relax me' and 'The way I communicate'. We also noted some of the information was unclear or missing, such as the name of peoples' spouses; which would be an important thing to know if someone wanted to have a conversation with someone living with dementia. One person's life story stated they liked their own company and had never been a social person, yet they were seen in a busy room with other people.

This raised questions about how well the information was being used, in terms of meeting people's personal preferences, and demonstrated that people were not adequately supported to follow their own interests.

The new manager provided evidence that activities and events were being organised for people and their relatives such as an Italian day and a high tea party.

People told us they knew how to make a complaint if they needed to. One person said: "I have nothing to complain about, it's all good." Another person added: "I never have complained, but I would tell the carer." A relative confirmed they knew what to do if they were unhappy. They told us: "I go to the manager."

We also received some written feedback from a relative who told us: 'I have never experienced a negative attitude from any of the nurses, and the Manager has an open door approach, she is out with the staff and clients all the time and if not she greets me with an open manner when I stand at her door which is frequent'.

A formal complaints procedure had been developed, outlining what people should do if they had any concerns about the service provided. We were shown a complaints log which was used to record any complaints and compliments received by the home, and the actions taken to address these. We noted that records provided a much clearer audit trail - from the original concern through to the actions taken to deal with these. We saw that concerns were dealt with in a timely manner and responses to people were also improved.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in January 2015, we found some areas that required improvement. For example, people reported problems with managerial oversight and approachability. They also said the culture at the home was not always open and inclusive. The provider was able to demonstrate that they had identified these issues before our inspection and had appropriate plans in place to address them. Therefore, we did not impose any enforcement actions on the provider at that time.

During this inspection, we found that there were still problems in terms of the leadership, management and governance of the home.

People using the service were not actively involved in its development. Prior to the inspection, we received information of concern about the leadership of the home. During the inspection, people and relatives confirmed that they often found staff and the management team to be defensive or difficult to get information from. One person told us: "You get the odd one or two who are up the scale a bit who are rude. They get very bossy with a bit of power." One relative said that senior staff often passed the buck, instead of taking responsibility for addressing the issues being raised. Another relative commented: "It is quite difficult to get information from staff. You feel awkward going to ask." We tried to talk to a member of staff during the inspection but found it difficult to get information from them. They made it clear through their body language that they did not want to talk to us. This raised concerns about openness and communication within the home.

No one, including people, relatives and staff, were able to give an example of when they had expressed a view and it had been acted on. People told us there were limited opportunities for them to do this. One person talked to us about meetings that had been held in the past for people living in the home. They said: "They used to happen, but only two or three residents go to them. People in bed can't get to them and nothing really changed afterwards." When asked, staff were not able to describe the organisation's values and ethos.

We were shown the results of a survey carried out in December 2015, which had asked people, relatives and staff to comment on how well led they thought the service was. This recorded that staff felt they were not encouraged to report shortfalls in care or incidents. Staff also reported that the management team were not aware of the atmosphere in the home and that they did not demonstrate positive behaviour. Relatives felt that they were not invited to attend meetings with the manager present, whilst people living in the home felt the manager did not allow them to make quality improvement suggestions. This raised concerns about staff and peoples' involvement in terms of opportunities to improve practice.

Although the provider had systems in place for monitoring the quality of the service provided, significant improvements were required to ensure actions are taken to address any service deficits identified, in a timely and effective way. The management team talked to us about audits that were carried out; to check the quality of the service provided. There was lots of evidence of audits and checks taking place. We noted that more recent audits had also been developed to correspond with the Care Quality Commission's five key

questions which we focus on when inspecting services - is a service safe, effective, caring, responsive to people's needs and well-led?

We saw a number of action plans that been drawn up as a result of the audits carried out, which provided clear information on areas that had been identified for improvement. These included many of the areas that we picked up on during this inspection. For example: staff training and knowledge, the use of observational charts, dignity and respect, activities for people living with dementia, nutrition, relative and people involvement, staff recruitment and workforce planning.

However, we were not assured about the effectiveness of the audits and action plans. For example, six weeks prior to this inspection, a 'mock inspection' was carried out by the organisation's director of compliance. This reported on problems with the use of observational charts in the home, and highlighted that they were too complicated and not always kept at the point of care. The report also stated: 'There is no evidence that they are being checked by management daily'.

We found evidence of a lack of oversight and monitoring in terms of records and charts during the inspection. Three people also told us that records maintained by care staff were not always accurate or completed at the time of care delivery. We noted from looking at people's observational charts that where entries had been made these had been recorded exactly on the hour or half hour e.g. 08:00, 09:00, and 09:30. We discussed this with the management team who acknowledged it was unlikely that staff would have been able to provide care at these exact times. This demonstrated that effective actions had yet to be taken to address the deficits identified in the mock inspection report.

We asked to see one of the observational charts that we had seen earlier in the day that had been incomplete. Not only had it been completed by this time, but it had also been completed 20 minutes in advance. This meant that a member of staff had recorded that they had provided care to someone including repositioning them, checking for broken skin and pain and offering them a drink, in advance. When asked, the staff member who had completed the chart said they didn't have a watch so had guessed the time.

We also found that medication had been signed for in advance, and inconsistencies with the way pressure mattress settings were being monitored and recorded. For example, records showed that one person's mattress had been set at 90 for approximately two weeks, before being changed to 60. Their weight had not changed dramatically according to their care records during this time and the mattress unit stated that 60 was the correct setting for their weight. When asked, the registered manager explained that 90 had been recorded in error, but this had been picked up during a recent audit. We could therefore not be clear whether the actual mattress had been set correctly during this time, as we could only go from the records that were being maintained.

These findings raised questions about the accuracy of other records maintained by the service.

Furthermore, areas requiring improvement that were identified at our last inspection in January 2015 had still not been adequately addressed. This included the arrangements for ensuring sufficient numbers of suitably qualified, competent, skilled and experienced staff; in order to meet people's assessed needs. One person was seen choking on food because a member of staff did not have the right knowledge to support them. This meant the arrangements to mitigate the risks to the person's health, safety and welfare, were inadequate.

In addition, improvements were still required regarding the provision of meaningful activities for people, including those living with dementia. Aside from external visitors and a flower arranging activity, we did not

observe any meaningful activities taking place during the inspection, which lasted almost ten hours. This demonstrated a lack of progress in meeting people's individual preferences and social needs, and had a direct effect on the quality of service they experienced.

These were breaches of Regulation 17(1) (2) (a) (b) (c) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection, the home has experienced a number of staffing changes, including at management level. Just before this inspection, we were informed that a new management team had been appointed, including a manager, deputy manager and a clinical lead. We met the new manager and deputy manager, but the clinical lead had not yet started. The new manager seemed clear about the task ahead of her and showed us a number of actions that she had identified, along with director of nursing and clinical services and the nursing manager for the service; to improve the service provided. She also told us she planned to apply to the Care Quality Commission (CQC) to register as manager.

We saw that systems were in place to ensure legally notifiable incidents were reported to relevant authorities, including the local authority and CQC. Our records showed that this was happening.

It was evident from speaking with the management team that there was provider level support for the new manager. It was also clear from the response we received after the inspection that the provider had once again taken our findings seriously. However, significant work was required to meet required standards and to be able to demonstrate a well led service, with a sustained delivery of high care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not consistently receive care and treatment in a safe way. Processes in place to manage risks were not sufficiently robust. Systems were in place to ensure people's daily medicines were managed in a safe way and that they got their medication when they needed it. However, these were not consistently followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not consistently met in accordance with their preferences and needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Arrangements to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff; in order to be able to meet people's needs, were not adequate.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect.

The enforcement action we took:

We issued the provider with a statutory notice called a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had systems in place for monitoring the quality of the service provided. However, significant improvements were required to ensure actions are taken to address any service deficits identified, in a timely and effective way.

The enforcement action we took:

We issued the provider with a stautory notice called a warning notice