Ringdane Limited

Gosmore Nursing and Care Centre

Inspection report

Hitchin Road
Gosmore
Hitchin
Hertfordshire
SG4 7QH

Tel: 01462454925

Date of inspection visit:
08 May 2018

Date of publication:
15 June 2018

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

This inspection was carried out on 8 May 2018 and was unannounced. At the last inspection on 5 April 2017, the provider was found to be meeting the standards we inspected. However there were some areas that required improvement. This was in relation to protocols for medicines prescribed on an as needed basis and care plans lacked sufficient detail to ensure people's individual needs and preferences were met. At this inspection we found that the previous areas that required improvement had mostly been addressed. However, we found that there were areas that were in breach of regulations. This was in relation to ensuring people's safety, staffing and governance systems to ensure standards were met Therefore this meant that this was the third consecutive inspection where the overall rating was requires improvement.

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

Gosmore Nursing and Care Centre provides accommodation and nursing care for up to 70 older people some of whom may live with dementia. At the time of the inspection there were 40 people living there.

The service had a manager who had applied to be registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

People were supported by staff who knew how to recognise risks to their safety. However not all staff knew how to report concerns externally. Risks were not consistently and robustly assessed and managed. People's medicines were administered in accordance with the prescriber's instructions. However, there were some areas that needed to be monitored. People and staff told us that there were not always sufficient staff available to meet people's needs. However we found that staff were recruited safely. Staff training was delivered by ELearning with some face to face training and supervisions had commenced.

The design of the building made it challenging at times to meet people's needs due to staff being spread across the home and equipment breaking down. There was a variety of food that people enjoyed. However further development was needed for the mealtime experience.

People were supported in accordance with the principles of the Mental Capacity Act 2005 and had access to health and social care professionals when needed. Staff were kind and attentive. However people were not always involved in the planning of their care and confidentiality along with privacy was not consistently promoted.

People received care that met their needs but this was not always person centred and needed further development. Most people's care plans provided staff with guidance to enable them to support people

appropriately. There were plans in place to ensure people were supported in accordance with their preference when they approached the end of their life.

There were systems in place to monitor the quality of the service and resolve any issues identified. However, these had not been robust as they had not identified all of the issues found during the inspection. The provider had not ensured that they were working effectively with other agencies to help improve the service provided. Due to a change of management structure they did not have access to the local authority's recent action plan or the Provider Information Return (PIR) which had been submitted to the Commission.

People were not always sure who the manager was but staff told us that they were regularly out of the office checking on staff and speaking with people. People, their relatives and staff felt the service was well run and complaints and feedback was responded to.

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 consistently safe.

People were supported by staff who knew how to recognise risks to their safety. However not all staff knew how to report externally.

People and staff told us that there were not always sufficient staff available to meet their needs. However we found that staff were recruited safely.

Risks to people's safety and wellbeing were not consistently and robustly assessed and managed.

People's medicines were administered in accordance with the prescriber's instructions. However, there were some areas that needed to be monitored.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The design of the building made it challenging at times to meet people's needs due to staff being spread across the home and equipment breaking down.

There was a variety of food that people enjoyed. However further development was needed for the mealtime experience.

People were supported by staff who were trained by ELearning and regular supervision was in place.

People were supported in accordance with the principles of the Mental Capacity Act 2005.

People had access to health and social care professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and attentive.

People were not always involved in the planning of their care.

Confidentiality and privacy was not consistently promoted

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received care that met their needs but was not always person centred.

Most people's care plans provided staff with guidance to enable them to support people appropriately.

There were plans in place to help ensure people were supported in accordance with their preference when they approached the end of their life.

Complaints and feedback was responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were systems in place to monitor the quality of the service and resolve any issues identified. However, these had not been robust as they had not identified all of the issues found during the inspection. This was the third inspection with the overall rating of requires improvement.

The provider had not ensured that they were working effectively with other agencies to help improve the service provided. Due to a change of management structure they did not have access to the local authority's recent action plan or the PIR which had been submitted to the Commission.

There was a manager in post who was in the process of registering with the commission.

People were not always sure who the manager was but staff told us that they were regularly out of the office checking on staff and speaking with people.

People, their relatives and staff felt the service was well run.□

Gosmore Nursing and Care Centre

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We also reviewed the provider information return (PIR) submitted to us. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.

The inspection was unannounced and carried out by two inspectors, an assistant inspector and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with eight people who used the service, five relatives, six staff members, and the regional manager who was supporting the service at this time, Regional Resident Experience Manager and the manager. We received information from service commissioners and health and social care professionals. We viewed information relating to 10 people's care and support. We also reviewed records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person said, "I am safer here than I was at home." Another person said, "I like it here, I am happy here." Relatives told us that they felt people were safe. One relative told us, "[Person] is safe and comfy here because the young ladies (carers) look after [them] for me, I know they do."

People were supported by staff who had a clear understanding of how to keep people safe. This included how to recognise and report abuse. Staff received training, but some were due for refresher training, and updates during a recent staff meeting. Staff did not all know how to report concerns outside to the service, for example, other agencies such as the local authority or the Care Quality Commission. We did note that information in regards to safeguarding people from abuse was displayed in the home. A visiting professional who regularly attended the home told us people were safe. They said, "I get very close with people and they talk to me. Everyone seems to be happy and I am confident they are safe."

Risk assessments were in place for areas including falls, skin integrity and the use of equipment. These assessments were detailed and identified potential risks to people's safety and the controls in place to mitigate risk. However other potential risks to people's health, well-being or safety had not always been identified. For example, the day of the inspection was warm and sunny, when we arrived at the home we noted that external doors all around the home were standing open to enable fresh cooling air into the home. This was acceptable at the rear of the building as the doors opened onto a secure back garden. However, the front of the building was open to anyone coming up the drive and people were vulnerable as unauthorised people could potentially enter the home unobserved. One staff member said that it was fine because the people in the vicinity of the open doors were not mobile and would not be able to leave the home unobserved. They were oblivious to the risk of unauthorised people gaining access to the home.

Accidents and incidents were recorded on a system which gave an overview of events and any action taken. However, we found that these records did not capture all appropriate action being taken in regards to unexplained injuries. We found that since January 2018, there had been 12 unexplained skin tears or bruises and one unexplained fracture. Records did not demonstrate that a full investigation had been completed, for example in relation to staff moving and handling training and techniques or themes with staffing. A relative told us, "An unexplained injury I complained about and they did look into it but couldn't find any explanation. I know they don't abuse people (this relative visits very frequently) but sometimes I just think they are short staffed and rushing." The action taken included reminding staff to be careful and, at times, consulting the GP. As a result of not completing a thorough investigation, the manager could not be assured that the injuries had not occurred due to poor handling or abuse and they had not notified the safeguarding team or the Care Quality Commission.

People's pressure relieving equipment was not robustly checked to ensure it was set correctly. Staff told us that people were assisted to reposition at appropriate intervals to help maintain their skin integrity and we saw that records were maintained to confirm when people had been assisted to reposition. We checked a random sample of pressure mattresses for people who had been assessed as being at risk of developing

pressure ulcers and we found that they were not all at the appropriate setting for their weight. This means that people may not be protected from developing pressure ulcers. One person who had developed two pressure ulcers was lying on a mattress that had not been accurately set for their needs. Staff were not able to confirm whose responsibility it was to check that mattresses were at the correct setting and not all staff were able to tell us what setting people should have or how to check it. A member of staff told us, "There is no-one specifically responsible, we all check."

A staff member told us that the call bells were not working. They were not working on Friday and the contractors were called out on Saturday and on Tuesday they were still not working. However people had not been told they were not working and neither had visitors. This meant that the call bell was buzzing in the person's room but not connecting to the system and so people thought it was operating and they had to wait. We also found, and staff confirmed, that there had been no additional checks put into place to ensure people were safe and not in need of support during the period of time while the call bells had not been working. One person who was in bed said, "I need the toilet and I can't reach my call bell." We did not see staff walking round and checking on people more frequently than the routinely planned hourly checks and staff were not always visible in the home due to the layout of the building and dependency needs. We noted that some people were heard to be calling out and another person was banging their remote control to summon a staff member. They told us, "I just bang my TV remote on the table until they come. Sometimes they don't give me the call bell so I have to bang something." We found that drinks were not always in reach and the weather was very warm. Following the inspection we received confirmation that the call bell system had now been repaired.

Personal emergency evacuation plans (PEEPs) for all people had been recently reviewed and indicated the support they needed to leave the home in the event of an emergency situation such as a fire. For example, one person's PEEP included that two or three staff were needed to support the person with using an evacuation sledge. It was not clear how the PEEPs had been developed, as there had not been any evacuation exercises to decide how people needed support and what time this may take. Staff told us that in the event of an emergency the senior staff would gather by the front door and make a plan of action, the care staff would stay with people to reassure them until instructed to do otherwise. A staff member said, "I did fire training about 16 months ago but have never done a practical exercise."

There were regular checks of fire safety equipment and fire drills were completed, however this had not included evacuating people who used the service. Staff told us that they had used the evacuation chairs to move people downstairs at times as the lift was broken. A fire risk assessment from November 2017 had stated that drills needed to be carried out for night staff and to include practising evacuation. The manager told us that this had not happened yet as they were waiting for their moving and handling train the trainer certificate to arrive so they could train staff in the use of the evacuation chair. However, staff had told us that they were already using the chairs, prior to training taking place and in the five months since the audit, they had not completed a night time fire drill. In addition, other areas on the assessment had not been signed as completed but they told us they had completed the actions.

Therefore, due to the concerns in relation to the security of the building, ineffective checks of the pressure care mattresses and the lack of systems to ensure people were safe during the broken call bell period, this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider ensured that checks, such as electrical or health and safety assessments, were also completed to help maintain people's safety.

People told us that there were not enough staff to meet their needs. One person said, "They are always short

staffed here – there are lots of agency staff and so you never know who anyone is." Another person told us, "It was 11 o'clock til I went down yesterday. I smoke and I was pretty desperate so yes they are short staffed." A third person said, "Sometimes you have to wait ages or they will come along and say 'back in a minute' but you never know if they are coming back soon or not." Relatives told us that there were not always enough staff available to meet people's needs. One relative said, "There are a lot of agency staff – it means they don't know people and sometimes they go in and don't say much and someone is half asleep and they start doing personal care and the person doesn't even know them." Staff told us that there were not always enough staff available to meet people's needs. During the course of the day there was a calm atmosphere in all units in the home and people appeared to receive their care and support when they needed it and wanted it. For example, one staff member told us that instead of four care staff on a unit as there was on this day there could very often be just two or three. This impacted on people because nearly all needed support of two staff for all their needs and if there were less than four staff on duty it meant that it took twice as long to provide people's care and there were no staff available to manage people's needs as they arose.

Staff told us there was a heavy reliance on agency staff whilst a recruitment campaign was being undertaken and that there were occasions when the agency had not been able to provide cover so they had to work short staffed. This meant that people did not always have their needs met when they needed or wanted. A staff member said, "We use such a lot of agency staff. I believe this is because the pay that care staff get is so bad that they quickly move on to get higher pay." Three of the eight care staff were agency staff on the day of this inspection.

Therefore due to people at times experiencing delays in having their needs met ands the deployment of staff not ensuring people had their needs met consistently in a timely fashion, this was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Safe and effective recruitment practices were followed to help make sure that all staff were suitable for working in a care setting. They ensured all required documentation was received before a member of staff commenced employment. This included written references and criminal record checks.

People's medicines were managed safely. At our last inspection we found that people did not have robust protocols in place for medicines prescribed on an as needed basis. At this inspection we found there were plans in place for most medicines prescribed on an as needed basis and gave staff clear guidance on when to administer the medicines. However, we did note one did not and another was not located with medicine records. Medicines were stored safely and administered by trained staff. We checked a random sample of boxed medicines and found that most stocks were accurate with the records. Two of the 12 boxes we counted had a discrepancy of one dose.

There were systems in place to help promote infection control. These included cleaning regimes and schedules and staff had received training in relation to safe infection control processes. The home smelt clean and fresh although we found some areas that required further attention such as bedrails and mattress pumps which were in places quite dirty. A member of staff told us, "Cleanliness was shocking when I first started here but it is much better now, there are cleaning schedules in place." However, we observed a staff member walking through the home with an armful of soiled laundry. They were not wearing gloves or an apron and the laundry was not in bags. We raised this with the management team.

The manager told us that lessons learned were shared at team meetings, supervisions or as needed. However, we noted that any issues were discussed and remedial actions put into place were not recorded as meeting notes were sparse with only a few words recorded and staff told us that they felt that formal

supervisions were not beneficial. We discussed with the management team the need to capture the information they discussed to ensure that they could demonstrate they were keeping staff informed.

Requires Improvement

Is the service effective?

Our findings

The design of the building made it challenging at times to meet people's needs due to staff being spread across the home and equipment breaking down. The layout of the home made it difficult for people to move around independently. It was set out over many different levels with ramps and steps. The lift had been broken for a number of months and there were a series of stair lifts installed. However one person told us using these could take up to 20 minutes for them to actually get downstairs so they chose not to bother. One person said, "They have put in a stair lift but I can't access it on my own because there are about six sets of stairs and you have to get up and get onto the next bit yourself so I have lost my independence because I have to rely on carers."

There were large comfortable lounges with ample seating for everyone and a large dining room so people could enjoy a meal together if they wished. There was an accessible garden that people were seen to be enjoying. However, due to the broken lift, there were several people who may not have been able to access the garden if they had wished. A relative told us, "We bought [person] a chair for £1600 and now [they] can't use it because there is no lift – [they are] just stuck in here and [they are] bored and the lift has been out of order for weeks, no months." One person who was unable to communicate verbally was pointing to the window where they could hear people in the garden and then pointing to themselves. We spoke with a staff member who told us they couldn't get the person outside or downstairs because of the lift situation. They told us the two lifts were not working – the main one but also one attached to the wall wasn't working either. We discussed the lift being out of service with the management team who told us that they were chasing the repair daily and they were waiting for parts. We noted that the lift had been out of order for a number of months on and off. Therefore this was an area that required improvement.

The environment throughout the home was warm and welcoming but a little tired in some areas. Some people's individual rooms were personalised with many items that had been brought in from their home such as cushions and pictures. We also noted that signage could be improved to make it more user friendly to enable people to find their rooms, bathrooms etc. much easier.

People were provided with a good choice of food and were supported to choose where they wanted to eat their meals. One person said, "The food isn't bad at all, there's always a choice and it hot." One person and friend told us about an incident where they didn't like the soup and so the friend told a staff member. The staff member told the chef and the chef came to see the person and asked what they would like. The person said asparagus and the chef provided them with some asparagus soup. However that one person told a staff member they did not like the chicken curry. The staff member offered something else but did not ever return with the alternative. This resulted in the person pushing their food around the plate and not eating very much. Some people opted to eat in the communal dining room and others chose to eat in their rooms. We noted that one person had pureed food and it was set out on the plate in a pleasant way. Tables were nicely laid with cloths and condiments were on the tables to support people to be independent.

People were provided with appropriate levels of support to help them eat and drink. However, we observed a person being supported to eat their lunch in their room, this was completed in silence, and the staff

member did not interact with the person at all. We later found that this was an agency staff member. However we also noted a similar experience in the dining room by a staff member employed at the home, who spent most of the experience speaking to their colleagues. We shared this with the management team as part of feedback at the end of the inspection.

Assessments had been undertaken to identify if people were at risk from poor nutrition or hydration. A relative told us, "They have a food chart for [them] and [they are] eating well now, better since [they] came here and will even engage." We noted that these assessments were kept under review and amended in response to any changes in people`s needs. Routine checks were undertaken in order to help make sure people maintained a healthy weight. However, fluid charts were not consistently completed which meant we could not be confident that people received their recommended daily fluid intake. For example, a complete day was missing from a person's fluid intake records. Therefore mealtime experiences and ensuring people are responded to in regards to alternative food choices and fluid chart recording was an area that required improvement.

People and their relatives told us that they felt staff were skilled and knowledgeable to support people living at the home. Staff told us they had received training to support them to be able to care for people safely however, they said that the vast majority of the training they received had been via e-learning. Staff said that they preferred face to face training as this engendered conversation and discussion around the subjects instead of being sat alone undertaking e-learning in isolation. The management team had an overview of the e-learning provision, who had done it and who had achieved a pass mark. However, there were no competency checks undertaken for the management team to satisfy themselves that the staff team had absorbed the learning and were skilled and knowledgeable to carry out their roles.

When agency staff were used to support the staff team the management obtained profiles of the staff members from the agencies confirming that criminal checks had been undertaken. Some of these showed that the agency staff members had received basic core training elements however, this was not consistent and some did not provide detail of the training attended. There was no evidence to confirm that this had been followed up with the relevant agencies. This meant that the management team had no awareness of the skills and knowledge of some of the agency staff working at the home. This was an issue due to the number of unexplained bruises or skin tears in the home that the manager told us may indicate poor moving and handling techniques. This was an area that required improvement.

The management team and staff confirmed that there was a programme of staff supervision in place. Staff we spoke with said they received support as and when needed and were fully confident to approach the management team for additional support at any time. However, staff told us that the current supervision arrangements were not an inclusive two way process. They generally did not get advance notice of a 1:1 and consequently were not able to plan what issues they may wish to bring up. They told us there was no discussion around personal development and no discussion about them as individuals.

Staff told us that when they first started to work at the home they had a mentor who they worked alongside to gain experience and to learn about how people liked to be supported. The staff member said they had shadowed their mentor for a month before they started to work unsupervised.

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).

Efforts had been made to ensure people's best interests were at the centre of all decision making when people lacked capacity to make decisions themselves. Our observations confirmed that staff explained what was happening and obtained people's consent before they provided day to day care and support. 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were in place, and it was clear that people had been involved with making the decisions and, where appropriate, their family members as well.

Staff offered people choices each day even when they were assessed as not having capacity to make some decisions. One person said, "I can get up when I want to, they wake me up but I don't have to get up."

People's day to day health needs were met in a timely way and they had access to health care and social care professionals when necessary. For example, GP, speech and language team (SALT) and a chiropodist. A relative told us, "A GP comes every week and if I wanted any more for [relative] then I would ask the nurse who would phone and get the GP in."

Requires Improvement

Is the service caring?

Our findings

People, and their relatives where appropriate, were not always involved in planning and reviewing their care. A person told us, "They've never asked me how they can help to look after me they just do it." Another person said, "There has never been any communication about a care plan." One relative told us, "We had a talk about care and a care plan a very long time ago – perhaps they are not as diligent as they should be." Another relative said, "They have never done a care plan, the other manager did mention it but it has never been done." People's relatives did tell us that if there was a change or a concern, staff did contact them to inform them. One relative said, "They do keep me informed, if anything happens they keep me informed by phoning me." However another relative said, "They never tell you anything here you always have to ask." This particular comment related to a SALT assessment which had been done but the relative didn't know if anyone had been to assess their relative's swallowing ability. We found the involvement of people and their relatives where appropriate was an area that required improvement.

Staff respected people's dignity and made sure that they supported people in the way they wished whilst encouraging them to remain as independent as possible. During our inspection we noted that staff were courteous and kind towards people they supported. We saw staff promoting people's dignity and privacy by knocking on people's doors and waiting before entering people's rooms. However we did also note one occasion where personal care was delivered while the bedroom door was open.

People's care records were stored in a lockable cabinet in a staff office in order to maintain the dignity and confidentiality of people who used the service. The office door had a key pad lock but was not locked at any time during this inspection. People's care plans were secured within a cupboard however there was a significant amount of personal and private information around the office within other records such as the staff communication book, the diary and weights records for example. Coupled with the fact that exterior doors were standing open for the entire day this meant that anyone gaining access to the home would also have access to people's personal and private information. This was an area that required improvement.

People told us that staff were kind and caring. One person said, "The carers are lovely, all of them and they try very hard and work very hard, they have to work really long hours." Another person said, "The carers are very kind." Relatives also told us that staff were kind. One relative said, "The staff are kind to [person] and I know that because [person] smiles when [they] see some of them." Another relative said, "The staff are nice, they don't have much time because they are always so pushed for time but they are very nice."

Staff were calm and friendly with people and we observed them interact with people in a warm and caring way. We noted that staff were attentive and knew people well. For example, we heard staff speaking with people softly, and asking if they could put a serviette to protect their clothes while assisting them with a drink. One staff member told us that two people who lived at the home had taught them a lot about gardening, this indicated that they had spent time with people listening and chatting. People were relaxed and comfortable to approach and talk with care staff and domestic staff alike.

People were encouraged to maintain relationships in whatever form they took. This included with family

members and friends. For example, we saw that there was a steady flow of visitors and two people had relatives stay for lunch. We also noted that when people were just starting to be served lunch, a visitor wheeled their relative through dining room and said to the staff member, 'I know rather impromptu but I am taking my [relative] out for lunch, as it's such a lovely day. Staff replied, 'no problem at all', and told kitchen straight away.

Relatives and friends of people who used the service were encouraged to visit at any time and felt welcome. One relative said, "One of the reasons I chose this place was because when I phoned they told me, "come any time to suit you, you don't need an appointment" and that made me comfortable that they haven't got anything to hide."

Requires Improvement

Is the service responsive?

Our findings

People received care that met their needs. However this was not always personalised. During the inspection we observed staff being prompt in supporting people and responding to their needs in a way that confirmed they knew people well. However, people told us although the staff were nice, they did not want to ask them to change their routines or request additional help. One person said, "Bath once a week that's all, I don't mind and I don't really want more but they don't ask what I want." Another person said, "I used to go to bed really late, midnight, but now they come to put me to bed at 6.30pm. The trouble is if you ask to change things it often doesn't turn out right so I just go along with it." A third person said, "They get me up at 6am, I don't really mind but they haven't ever asked me."
We were told by one person that they had asked for their continence product to be changed during the night and the staff member had told them no as it wasn't due. The person did not want to be identified so we were unable to follow this up with the management team. However, we noted that there had been a complaint relating to continence products not being changed and we asked the management team if they had been aware of these concerns and any themes in this feedback. They told us that they were not. We also were told that people were given a bed bath or strip wash instead of a bath as the bath was broken. A relative told us, "[Person] has a shower in the upstairs bathroom because it is a proper wet room." We asked how they managed to take the person upstairs and the relative asked a staff member who told them, "No we give [them] a bed bath because we can't get [them] to the shower room, the lift is broken." Another relative said, "[Person] can't access the bathroom [they] need to for a bath, the bathroom along the corridor has been out of action and the lift is out of action so [person] hasn't had a bath since [they] came here last year. Only bed baths and we have had to ask them to wash [their] hair." However, the management team were not aware of any baths being broken so we asked that they check if this was common practice in the home.

Three people told us that they had both male and female staff supporting them but they had never been asked what their preferences were. One person said, "The carers are all really nice so I don't mind but I've never been asked." We found that person centred care was an area that required improvement.

At our last inspection we found that care plans lacked sufficient detail to ensure people's individual needs and preferences were met. At this inspection we found that most people's care plans provided staff with guidance to enable them to support people appropriately. We found the plans were detailed and person centred. They included information that enabled staff to promote independence where people were able and provide care in a way people preferred. For example, the care plan detailed that they liked their bedroom curtains drawn at night, their bedside light on and their bedroom door closed. However, this was not consistent. For example, a care plan for a person with capacity stated that they liked a strip wash daily and a shower once a week. However, there was no information to guide staff about the support the person needed to have a shower or how they wanted staff to provide the strip wash.

We found there to be clear handover template sheets which were pre-populated with information about people's mobility needs, diet and basic health needs. Also indicated people's preferred time of rising, for example one person preferred to rise at 0530 hours, staff supported this.

There were plans in place to ensure people were supported in accordance with their preference when they approached the end of their life. We found that where staff had needed to support people and their families at this time, they had ensured that people had died with dignity and without pain. Staff were trained to enable them to support people appropriately.

People were supported to participate in activities in and outside of the home. The service was working in reflecting hobbies, interests and preferences. One person told us that they knitted soft toys to sell at the fete and said, "[Activity organiser] provides the wool and I knit and then [the activity organiser's) mum stuffs them and they sell them, it gives me something to do." However to do this they needed to speak with people and find out what they enjoyed. One person told us, "The activities lady [name] arranges all sorts but there are no activities at all on Wednesdays or in the evenings or weekends. I go downstairs to activities." Another person who was bedbound said, "No one asks what I like or don't like or what I want to do." A third person said, "No one has ever asked me what I did in my life before I came here, no not ever." Relatives told us that staff did not always ask what people enjoyed doing. One relative said, "The activities lady did ask what [person] liked about two years ago but nothing since."

There were a variety of activities taking place throughout the home during the course of the inspection. For example, some gardening. In the afternoon a quiz took place in the garden and there were lots of hats in a box available for use to protect from the sun and large shady umbrellas. The activity co-ordinator told us of other in house activities that people enjoyed such as cheese and wine afternoons. They told us that there were some days when people didn't want to do an organised activity and said, "So we just sit and chat, they really enjoy that." There was a bake off competition due to start whereby staff and relatives baked cakes and a panel made up of people who used the service were nominated as judges.

The activity co-ordinator told us that they routinely visited people who were isolated in their rooms to sit and chat or do a one to one activity such as play a game or paint their nails. However, during the course of this inspection we did not see this happening.

Trips away from the home were arranged for those people who wished to attend. For example, a trip to a country estate park, to the seaside. People said they wished to see the London Eye so a trip was being organised to do this. The manager also told us, "As part of fulfilling residents dreams we are looking at taking one individual to York Railway Museum (related to past work), and group outing to London zoo."

The activity co-ordinator had worked at the home for a significant period of time and knew each person very well. There was no activity provision for one day in the week and at weekends. We asked the management team about this and the manager told us, "On the other days the (care) staff spend time with people." However a person told us, "The carers don't have time to talk, it would just be nice for someone to pop in for a chat." Another said, "There haven't been activities for about a month because [they've] been off sick." We did not verify this on the day of inspection but it was clear that this person had not received any activities. We informed the management team of our concerns in regards to social isolation for people in their rooms, particularly as the faulty lift meant people who may previously have come to communal areas, were unable to. The consistent provision of activities, with particular attention to those in their rooms, and ensuring they linked to hobbies, interests and preferences, was an area that required improvement.

Complaints and minor concerns raised had been fully investigated or were in the process of an investigation. People and their relatives told us that they knew how to raise concerns. We noted that there had been a complaint about a staff member and the management of this was to stop the staff member being involved in the person's care. However, a further complaint was received as the staff member was involved at the time of the person's death and therefore the management plan had not been effective.

People, relatives and professionals were asked for their views through a survey. There was an iPad in reception so that relatives and visitors could give their feedback anonymously. To capture people's views, as part of a care plan audit, people were asked for their views. The manager told us that this had been key in identifying issues with the menu and they had been able to resolve it. We noted that there had been no recent concerns about the quality of the food or the menu so the capturing of the information had been effective.
There were regular meetings held for people who used the service and their relatives to share their opinions about the service and facilities provided. Minutes were taken of these meetings however were not detailed so it was not possible to gauge if people were able to positively influence the service they received. One relative told said, "[Relative] has been here two years and I've been to one meeting. They just stick notices on doors but I don't think I have missed anything." Another relative said, "We do get a questionnaire, not often, perhaps once a year if that." A third relative said, "They aren't good at telling you things here, the staff don't communicate with the relatives you always have to ask."

The manager told us to ensure people, relatives and visitors received up to date information, "We are going to put up 'you said we did' board and 'meet the team' board." We saw this had been delivered and was in reception waiting to be put up.

Requires Improvement

Is the service well-led?

Our findings

The registered manager left the service before this inspection. The home was currently being run by a manager who started at the service in November 2017. In addition there had been a change to the deputy manager and regional manager. Staff were positive about the current manager. One staff member said, "The home is better led now, the manager encourages staff to speak with him, this didn't happen under previous management."

People and their relatives gave mixed views about the management team and how the service was run. One person said, "I know his name but he's not around much, if I had a problem I would probably talk to [deputy manager]." A relative said, "I know the Manager's name but he isn't very visible."

Overall, the manager was personable and staff clearly found them to be an improvement on the previous home manager. However, management of records throughout the home needed improving and as a result part of inspection process was made difficult by trying to access information. We found when we asked questions, they told us issues had been resolved, such as training bookings, but when we explored it further, we found that issues had not been resolved. For example, they were still planning to book the training.

Staff told us that the management team was approachable and that they could talk to them at any time. They said that the management was always open to suggestions from the staff team and that they listened to everybody.

Staff told us that there were regular staff meetings held to enable them to discuss any issues arising in the home. However, the minutes seen did not reflect the substance of discussions held, they were just a collection of key words. There were no agendas to structure these meetings and no action plans were developed as a result. This made it difficult to assess their effectiveness and if staff were given any information in relation to learning from issues, complaints or incidents.

There were systems in place to monitor the quality of the service and resolve any issues identified. However, these had not been robust as they had not identified all of the issues found during the inspection. This was in relation to management of pressure care equipment, managing of risks within the home and records, which included meeting notes to ensure they captured the content of meetings. This was an area that required improvement.

There was a regular regional manager visit and they completed audits to help ensure the home was working in accordance with legislation and provider policies. We saw that actions arising from these visits were shared with the home manager and these were dated when completed. However, the system used was not easy to follow and all outstanding actions where not linked which made it difficult for the management team to have an overview of all the areas that needed to be addressed. This was particularly important due to the management team changes. Following the inspection the manager sent us an action plan to address some of the issues they were made aware of by us during feedback.

The provider had not ensured that they were working effectively with other agencies to help improve the service provided. Due to a change of management structure they did not have access to the local authority's recent action plan or the PIR which had been submitted to the Commission. A recent monitoring visit form the local authority had been positive in some areas with some other areas being identified as requiring improvement. There was an action plan to be completed and although we saw that the shortfalls identified by the local authority, such as ensuring the service adhered to the principles of the MCA 2005 had been addressed, the management team did not know the full extent of the action plan and did not have a copy of it. The service was also supported by a local care provider's association who provided support with activities and training to help keep knowledge up to date. However they had not yet fully utilised this to help them achieve actions on their PIR and local authority action plan, such as additional training to develop staff skills. For example, champions in key areas such as falls, nutrition and dementia. This was an area that required improvement.

Due to the issues found as part of the inspection, this was the third consecutive inspection where the service was found to be rated overall requires improvement. Therefore this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The provider had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the security of the building, effective checks of the pressure care mattresses and had a lack of systems to ensure people were safe during the broken call bell period

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service had been rated requires improvement for three consecutive inspections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure appropriate deployment and management of staff to ensure people's needs were consistently met in a timely manner.