

Four Seasons (Bamford) Limited

Keresley Wood Care Centre

Inspection report

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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

This inspection took place on 25 May 2016. It was unannounced.

Keresley Wood Care Centre is a nursing home which provides nursing care to a maximum of 44 people. Forty three people lived at the home on the day of our inspection. The home operates on two floors. The ground floor accommodation consists of a lounge, a dining room, a larger lounge/dining room and bedrooms. The first floor has bedrooms only.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We refer to them as the manager throughout this report.

At our last inspection visit in January 2015 we found the registered manager had not sent all statutory notifications required to us and this was a breach of regulation. These were notifications to inform us of deaths and incidents that affect the health, safety and welfare of people who live at the home.

Following our last inspection we asked the provider to send us an action plan outlining the improvements they intended to make. At this inspection we found improvements had been made however two notifications we received were not completed in detail and referrals to the local safeguarding authority were not made. The provider had addressed this prior to our inspection visit.

People who lived at Keresley Wood Care Centre and the staff who supported them, thought people who lived at the home were safe. There were systems and processes in place to protect people from the risk of harm. However, everyone we spoke to at the home told us there were insufficient numbers of care staff to provide care and support to people at the times they needed it.

Some people and relatives were unhappy with the care provided and expressed concerns about the length of time they, or their relations, had to wait to receive care. Staff were committed to providing a good standard of care but we observed there were delays in attending to the personal care needs of people. People did not consistently receive baths and showers when they wanted them and there were delays in people being assisted to use the toilet.

We observed, and people told us, staff members were caring but did not have time to interact with people unless they were providing personal care and we saw some people were left for long periods with little interaction. Call bells were not always in people's reach when they needed to request support from staff.

Staff did not consistently receive support from the provider and manager to enable them to provide

effective care to people. Only 50% of staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). There were policies and procedures in place to ensure that people who could not make decisions were protected, however we found appropriate assessments had not always been completed in detail. This was being addressed by the provider and training was taking place on the day of our inspection.

We saw people received a good choice of food and drink, and people's nutritional needs were met. We saw that staff supported people to eat and drink, however some people told us drinks were not always available when they wanted them. Records related to people's food and fluid intake were not in place in order to ensure their health and well-being were being maintained.

People's health needs were met. We saw some appropriate referrals were made to specialist healthcare professionals where people needed support, for example with eating and drinking and skin breakdown.

Care plans and risk assessments contained information that supported staff to meet people's needs. However some had not been updated when there had been change in people's care needs and some initial assessments of people's individual needs were not completed in detail. There was a risk that staff would not have up to date information on risks to people and how to keep them safe. People and their relatives were not consistently involved in the planning of care being provided.

Records did not always reflect the care and support people required or received. Some wound care charts did not contain sufficient information on pain management and people's daily records were not completed accurately to show they had received personal care.

Staff treated people with kindness. Staff had a good understanding of people's needs and most supported people with respect, however some people told us staff did not consistently ensure their dignity was maintained at all times.

The provider employed an activity worker to support people with their activities, hobbies and interests. However we saw they were often involved in other duties around the home which reduced the time they were able to spend supporting people. Staff felt supported by the registered manager but did not feel the provider was supportive.

The provider had recruited a new area manager to support the registered manager. They were both open and transparent about the improvements that needed to be made in the home and the provider had taken immediate action to address the issues we highlighted.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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?

The service was not consistently safe.

People told us they felt safe however staffing was insufficient to meet people's needs and people did not consistently receive care and support at the times they needed it. Staff knew what action to take to protect people if they thought a person was not safe. Medicines were mostly administered and stored safely.

Requires Improvement ●

Is the service effective?

The service was not consistently effective.

People were supported to have a nutritional diet however drinks were not always available at times people wanted them. Staff were aware of their responsibilities regarding the Mental Capacity Act and Deprivation of Liberty safeguards. However not all had received up to date training and documentation and assessments were not consistently completed correctly

Requires Improvement ●

Is the service caring?

The service was not consistently caring.

People did not consistently receive personal care that met their individual needs. Individual staff members interacted with people in a caring and respectful way but did not always have time to engage with people outside of delivering care. People's privacy and dignity was not always maintained.

Requires Improvement ●

Is the service responsive?

The service was not consistently responsive.

People did not always receive care which was responsive to their needs. People's interests were supported by an activity worker however they were often involved in other tasks around the home. Visitors were welcomed at the home. Complaints were recorded and responded to in a timely manner.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

Requires Improvement ●

The provider had recruited a new area manager to support the home. However the provider had not ensured there were sufficient numbers of care staff to support the needs of people. Staff felt supported by the manager but did not feel the provider supported them. The provider had systems in place to monitor the quality and safety of service provided but these had not identified some of the issues we found.

Keresley Wood 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 May 2016 and was unannounced.

This inspection was undertaken by three inspectors, an expert by experience and a specialist advisor. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge of nursing. An expert-by-experience is someone who has knowledge and experience of using, or caring for someone, who uses this type of service.

Before the visit we looked at the information received from our 'Share Your Experience' web forms, and notifications received from the provider. These are notifications the provider must send to us which inform of deaths in the home, and incidents that affect people's health, safety and welfare. We also contacted the local authority commissioners to find out their views of the service provided; they had identified areas of concerns and were monitoring the service.

Before the visit the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to review the information in the PIR during our inspection. We found it did not fully reflect the service we found.

We talked to 11 people who used the service and six relatives and friends. We interviewed 11 staff (this included nurses, care workers, domestics, and maintenance and kitchen staff). We observed the care provided to people and reviewed five care records.

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

We also reviewed records to demonstrate the provider monitored the quality of service (quality assurance audits), medicine records, two staff recruitment records, and complaints, incident and accident records. We also spoke with the registered manager and the area manager who attended the inspection.

Is the service safe?

Our findings

Everyone we spoke to at the home told us there were not enough staff to provide care and support to meet people's needs. People told us, "There are not enough staff, yesterday there was a young carer running up and down, she didn't have time to spend with anyone." And, "No there are never enough staff; even my family think there is not enough. Under the circumstances staff do a miracle to get done what they do. They work from 8am to 8pm it's a long day for them."

We spoke to several staff and one informed us at 4:30pm there were still three people waiting to receive their daily wash. Another told us, "Staff can't give people as much time as they would like to. We are trying to look after residents but rushing it. If we had 20 residents who could wash themselves it would be different but we haven't."

At 3:40pm we were speaking with the area manager in the main office when a relative knocked on the door. They were distressed and wanted to know why their relation was still in bed. They said they had tried to find out from staff why this was but had not been given an answer. They told us, "I can't fault things here usually, but I am upset, [person] should not still be in bed." The area manager informed the manager who came to speak with the relative. Later on we saw this person was out of bed and sitting with their relative in the lounge.

Several people living at the home were nursed in bed due to their poor physical health and required regular personal care and repositioning to prevent their skin from becoming sore. Staff told us it would often require two staff members to provide care and support to each person. The manager told us that six care staff and two nurses were normally on duty during the day and at night four care staff and two nurses. The manager told us they had increased the number of night time care staff after visiting to carry out a 'spot check' audit at 8:30pm the week before our visit. They commented, "I was here until 2:30am and the staff never stopped and didn't have a break. The staff are trying to do their best." They had raised their concerns with the area manager.

The manager informed us they were employing agency nurses on night duty to fill gaps in the staffing rota and they tried to ensure continuity of care for people by using agency nurses who were familiar with the home. The provider confirmed they were in the process of recruiting more nurses to the home.

We saw minutes from a recent team meeting in May 2016 where staff spoke of their concerns about staffing levels. It was recorded they felt unable to provide quality of care to people as they were rushed and had no time. They also reported that staff morale was low and relatives had complained to them about the lack of staff. The manager had informed them that staffing hours were not being cut and the provider was looking to recruit more 'bank staff' (temporary relief staff permanently employed by the provider) to provide additional support. Staff told us that there was now fewer care staff on duty to provide care and support to people.

One member of staff we were speaking to became distressed and told us they felt unable to meet people's

needs. Another said to us, "They are not getting proper care. Everything is late, by the time we do our first washes; we have people buzzing for help."

At 10:17am we heard one person who was in their bedroom on the first floor calling "Please help me." We responded to see if this person required some assistance and then went to find a member of staff. We were not able to find a member of care staff until 10.23am on the ground floor. We also heard another person calling for assistance and we discovered they did not have a call bell available to them to request staff attendance. We pressed the call bell which was on the wall and after five minutes of waiting we went to find a member of staff. Another person we spoke to told us they were cold and in pain and had told staff but they had not yet responded. We spoke with a member of staff who went to give assistance to the person.

We observed the activities coordinator was assisting with handing out drinks and they informed us they would also assist people to eat, and on occasion provide support in the kitchen. These additional duties impacted on their main role which was to provide activities with people.

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

The provider used a dependency tool that would indicate the numbers of staff required to meet the dependency needs of people. The area manager told us that staff numbers had recently reduced as the tool had indicated the home was over staffed, based on the care needs of the people who currently lived there. We spoke to the area manager about these concerns and they informed us they would review staffing levels as a priority and review working patterns.

The provider had a 'resident's experience team' and their role was to provide support to homes where areas of concern or additional training needs were identified. The area manager informed us one member of the team would now be allocated to support the home and reassess the dependency needs of all people living there to ensure they were correct. This meant the dependency tool would have accurate, up to date information entered to ensure the appropriate numbers of staff were available to support people.

The area manager told us, "We need to look at a more effective way of working; I want all staff here to roll up their sleeves and join in." Following our inspection visit they informed us they had raised our concerns with the provider's senior managers.

People who lived at Keresley Wood told us that they felt safe. One person said, "Yes I do feel safe as there are always people about and I have a buzzer should I need help." Another told us, "I feel safe here, I'm lucky to be here." A relative told us, "[Person] is safe here, she hasn't had any falls, but then she spends all day sitting in a chair."

We looked at what procedures were in place to ensure that risks related to people's care needs were identified and managed safely. We looked at the care records of five people and saw risk assessments were not always completed in detail. For example one care plan stated the person was unable to move themselves in bed and was at risk of skin damage. They needed to be moved regularly to prevent their skin from becoming sore. This person did have skin damage and whilst there was detail on how to support the person to be repositioned in bed there was no information on how often this was to be done. Staff were regularly repositioning the person but times were not recorded to demonstrate the frequency.

The home had the equipment necessary to keep people safe. For example, people identified at risk of skin damage had pressure relieving cushions to sit on and alternating pressure mattresses to sleep on to reduce

the risks. Those who were at risk when moving had the appropriate equipment such as hoists and slings to support them. Staff were knowledgeable about people and risks and how these were managed.

We spoke with staff about safeguarding procedures. Staff were clear about their responsibilities to report these incidents to the manager and the provider had a policy for informing staff of the correct procedures to follow. However prior to our inspection visit we had received notifications from the provider regarding two incidents that had not been reported to the local safeguarding team. We spoke to the manager at the time and they addressed this immediately with the member of staff who had completed the notifications, and additional training was provided to them. The relevant referrals were then sent to the safeguarding authority.

We checked the administration of medicines at the home to see if they were managed safely and whether people received the medicines prescribed to them. One person said, "It's good because the nurse does it." Another told us, "There is no problem with medication in the home." We observed the nursing staff administer medicines to people. They ensured they were giving the right medicines to the right person and took time to ensure the medicine had been taken.

We looked at one person's notes who was having a medicine patch applied to relieve their pain symptoms. The medicine was a controlled drug and these medicines need to be carefully monitored and accounted for due to their strength. We saw that a new patch had been applied but the old one was not located on the person. This meant that the person may not have received their complete pain relief treatment and the old patch could not be safely disposed of.

A number of people were prescribed PRN, 'as required' pain relief but their records did not tell us how their pain levels were monitored or assessed by staff. This is important, especially for people who cannot communicate, to ensure they are kept free of pain and comfortable. Where protocols were in place for people who required PRN medicines, there was minimal information to guide staff on when they should receive them and why they were given. For example, we saw one person who could not communicate had been given a medicine to reduce their anxiety; however there was no information recorded as to why they may be feeling anxious. Nurses we spoke to did not have a clear understanding of the use of protocols.

We also found there was no up to date pain score tool in place. These are used to assess how much pain a person is experiencing and how the service assesses and responds to pain. The registered manager acknowledged this and following our inspection they told us, all care plans were being re written and more information regarding pain management was being introduced.

We found medicines had been stored safely and in line with legal requirements and there were good systems in place to manage and dispose of unwanted medicines. We looked at a sample of medicine administration records (MAR), and records for the administration of controlled drugs. We found the records accurately reflected the medicines taken and the number of medicines available to use.

We asked about incidents and accidents in the home and what actions the provider took to reduce the likelihood of them happening again. The manager told us information was recorded onto a 'tablet computer' and that this could be done by any member of staff. The manager would then analyse the information and put action plans in place to make improvements, such as updating people's risk assessments or referring them to healthcare professionals for support. We saw evidence this was carried out.

The provider's recruitment process minimised risks to people's safety because checks were made to ensure

staff who worked for the service were of a suitable character. Staff told us and records confirmed, Disclosure and Barring Service (DBS) checks and references were in place before they started work. The DBS helps employers make safe recruitment decisions by providing information about a person's criminal record and if they are barred from working with people who use services.

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. 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.

The MCA and DoLS require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. The provider had submitted applications for nine people to the local authority, however the information provided on the forms did not state what restrictions were in place for the individuals and the information recorded was not clear. We spoke to the member of staff who had completed these forms and they told us they had not had not received training in DoLS or MCA and that completing the necessary applications was, "A stab in the dark."

We saw in some care records that people had been assessed as having capacity to make decisions but they had not been reassessed if their capacity had changed. For example one person's records stated they had full capacity but this had been crossed out and recorded as "variable" with no supporting information to show that a new assessment had been carried out. Another person's records had not been updated to demonstrate their capacity had changed. This meant that people had not been correctly assessed and best interest decisions made where necessary to support their wishes and feelings.

One person had bed rails in place but there was no recorded best interest decision why this was necessary as the person had limited movement. Overall we found that care plans contained inconsistent information about people's mental capacity and some did not identify that healthcare professional or family members were involved in making best interest decisions for people. This information would be vital to help inform staff with the specific decisions people required help and support with.

We looked at the training records and found the provider had not provided training to 50% of staff around the Deprivation of Liberty Safeguards (DoLS). The manager acknowledged that further training was required. The provider was providing this training on the day of our visit which the manager had been attending, but they returned back to the home to speak with us. The area manager advised that training to all staff would be reviewed immediately to ensure staff were following the Mental Capacity Act in full.

This was a breach of Regulation 11 (1) (2) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent

We found some staff were knowledgeable about people who lacked capacity and some people had been correctly assessed and best interest decisions made in how they received personal care and support with their financial decisions.

We asked people if they thought the staff had the skills and knowledge to meet their needs. One person said, "When I am being moved in the hoist I don't feel safe then, I don't like it. Staff know what they are doing and make a joke to reassure me but I just don't like it."

Staff had been given training on induction when they first started working at the home to ensure they provided care safely and effectively. Staff told us they had received e-learning in areas considered essential, which included infection control and moving and handling people. They told us they found this useful to help them carry out their role effectively.

We looked at the staff training records and saw that some staff still required training in areas the provider had considered necessary in order to meet people's care and support needs. We asked the manager about this. They informed us they had written to all staff informing them they must complete all of the required training. The manager also informed us they had requested additional training for nurses around male urinary catheterisation to avoid unnecessary hospital attendance for people who had problems with their catheter.

The manager informed us the provider had recently commenced training in line with the Care Certificate for new staff. The Care Certificate assesses the fundamental skills, knowledge and behaviours of staff that are required to provide safe, effective and compassionate care to people.

We observed staff moving and handling people and saw they were using equipment safely and reassuring people when they were being moved. We saw that when a person had asked for help to move staff gave them clear instructions on what to do and waited for them before moving on to the next step. This included telling the person where to position their hands on a walking aid, supporting them to stand and asking them to bend their knees so that foot plates could be correctly positioned in a wheelchair.

Staff we spoke to told us they had regular one to one meetings (supervision) with the manager to discuss their performance and any concerns they may have. We saw a timetable which identified when staff were due to meet with the manager for their next supervision sessions and annual appraisals so that staff received regular support. The manager informed us they would be holding meetings on a monthly basis for individual and group sessions.

We asked people if they had enough to eat and drink and received mixed responses. Some people told us, "The cooking is brilliant but depending who is on and how many, some days you can go all day before a jug of water is delivered. If the right people are on I am always alright for food and drinks." Another commented, "It is hit and miss with the drinks." We overheard a person calling for assistance as they did not have a call bell. They told us that they wanted a drink and we saw that it had been placed out of their reach. We discussed these comments with the manager and area manager and they assured us this would be addressed immediately. Following our visit the manager told us they, and the nurses, were closely monitoring that people had regular access to drinks.

A relative contacted us prior to our visit and told us that drinks were not always available. We had discussed this with the manager at the time who assured us fresh jugs of water were given out daily and the person to whom this related also received regular fruit juices. At this visit we overheard one relative say to their family member, "Oh, you have a drink today." This implied this was not a regular occurrence. The area manager informed us after the inspection that immediate action had been taken to ensure people had regular access to drinks.

We saw drinks being served to people; however we observed that some people who required thickeners to

be added to their drinks to reduce the risk of choking had un thickened water in jugs within their rooms. These were all out of reach of people and we addressed this with the manager at the time to gain assurance people would not be offered drinks that did not contain thickener. They told us drinks were thickened at the time the person required them and staff would add thickener to the water before giving it to the person. We saw people received their thickened drinks and staff had a good understanding of who should have their drinks thickened.

We saw staff provided one to one support to people who needed assistance with eating. This was carried out at a pace which allowed the person to eat without feeling rushed and maintained their safety. One staff member noticed that a person had not eaten any of their meal and asked if the person would like any help. When the person indicated that they wanted help, the member of staff sat with the person and helped them to eat their meal.

The cook informed us there were people living at Keresley Wood who required soft food diets, mostly because of health reasons such as swallowing difficulties. We observed a meal at lunchtime and saw people were offered a choice of scampi and chips, roast beef, and a selection of vegetables. A member of staff told us that they had made fish for one person who did not like the other options. For people requiring a soft diet a turkey mince puree or vegetable soup had been prepared and staff asked people which meal they would prefer. This showed that people had a choice of meals.

Records confirmed that referrals had been made to professionals such as dieticians when staff were concerned about a person's weight loss. People had been referred to other health professionals when necessary. We saw referrals to the speech and language therapists and GP's visited the home regularly to review people's care. However guidance was not consistently followed regarding how frequently people should be weighed. One person's records indicated they should be weighed weekly but this had not been consistently carried out.

Is the service caring?

Our findings

During our inspection visit we heard staff speaking kindly to people and saw they were respectful, however as staff were busy we saw little interaction with people outside of providing support.

There were mixed views from people and relatives about whether staff were kind and caring. One person told us, "Sometimes I feel they don't know who I am. I am a person, not just someone who is in here."

However other people commented, "Staff do a marvellous job. They try to work on the two floors and it is a fine art juggling those who are cared for in bed." Another told us, "Carers are absolutely fabulous, but there are not enough of them, no way could I do what they do."

We found most staff were highly motivated to meet the needs of people living at the home but many expressed frustration they had insufficient time to provide the care required. One staff member told us, "They've got good staff here but they're rushed off their feet. The residents are very high dependency. They should have the best of everything."

On the day of our visit, several people who lived at the home were cared for in bed, due to their physical conditions. Care staff ensured people's privacy was protected when providing personal care and closed bedroom doors. However we observed two occasions when they did not knock on the person's door to gain permission to go in. We found one person had removed their bed clothing and was exposing their body, their bedroom door was open, and we covered them to protect their dignity.

Some people told us they did not feel staff respected their dignity, one person told us, "A short while ago I was waiting for my medication for ages and I needed to go to the toilet. In the end I had to use the bathroom, I was sitting on the toilet and the nurse came with my medication. ...she opened the door and whilst I am sat on the toilet she squeezed the medication onto my mouth. I don't think that showed privacy or dignity."

Other people felt staff did respect their privacy and dignity, one commented, "Staff do respect my privacy and dignity. They cover me up when washing and creaming me." Another told us, "They have male carers here, they ask me if it's ok before helping me and they don't make me feel awkward; all the staff are so caring. You don't feel that when they have walked out the door they have forgotten you."

People did not always receive baths or showers when they wanted them. One person at 12.30pm told us, "I have not had a shower since I've been here and haven't had a wash yet today." We asked another person if they had regular baths and they told us, "Well no I don't, but I would love a bath." One relative we spoke to told us they had been concerned that their relation was not having baths, they told us, "Overall my main concern is [person] doesn't get showered. They gave him a bed bath and they did it really well."

Staff said that, due to the number of staff on duty, there were many times that people could not have their wash until the afternoon and people only received one wash a day. One member of staff told us, "Instead of

showering, we will wash people in bed. Even though we struggle, we do look after residents, we put them first."

We discussed this with the manager, they told us these concerns had already been identified and they were in the process of addressing them. They also told us once the staffing levels were appropriate this would provide more time for personal care to be delivered. The area manager told us they would inform all members of staff, including the nurses that they were to support people with their personal care. During our inspection visit we saw people appeared well cared for and their bed linen was clean.

We observed staff communicated with people effectively and used different ways of enhancing their communication by touch. They bent down to speak with people who were sitting and used gentle reassuring tones when talking. Interactions between staff and people were warm and compassionate but limited to when personal care was being provided. Staff reassured people who were anxious and responded promptly, calmly and sensitively and spoke to people in a caring way.

One member of staff saw that a person was acting in a manner that was not usual for them. The member of staff sat and spoke with them and found out that they had experienced a nightmare the previous night which had upset them. The member of staff offered this person comfort by speaking through the events of the nightmare and helping the person to focus on what was happening that day. By the end of the conversation the person was calmer and smiling.

The home provided care to people when they were reaching the end of their lives. Plans were put in place to make sure people received treatment which would reduce pain and make them more comfortable. We saw these plans were followed.

People were encouraged to maintain relationships important to them and visitors were welcomed at the home. Relatives we spoke with told us they were able to visit their family members when they wanted or where invited to by their relation.

Confidential information was kept securely to maintain people's privacy, for example daily monitoring records were kept in the person's own bedroom. We saw care records were kept in the nurses' station in lockable cabinets.

Is the service responsive?

Our findings

We looked at four people's care records to see if care was planned and delivered around people's individual needs. Some of the care plans and assessments lacked important information. For example one person's care plan had identified they were unable to communicate as they were unable to speak English. There was no information on how staff could effectively communicate with this person. The assessment did not show what steps the staff had taken to improve communication, for example by the use of an interpreter.

There was no information on how to correctly move the person in bed as they were unable to do this for themselves and they were at risk of skin damage because of unrelieved pressure. This person was being treated for existing wounds. However the documentation gave little information on the severity of the wounds and how pain levels were being assessed and managed when their wounds were being redressed. Where there had been a change in the condition of the wound the care plan had not been updated. This person had been referred to a specialist nurse who had carried out an assessment and provided advice and directions on how to dress the wounds and how often to reposition the person to relieve pressure.

This person required full support from staff with their personal care however their plan simply stated "All care two carers". There was no information recorded how the person liked to receive their care. However staff had a good understanding of how to meet this person's care and support needs and followed advice from supporting healthcare professionals. We brought this care plan to the attention of the manager who told us this would be reviewed immediately.

Some people told us they had not been involved in formulating and reviewing their care plans. One person told us, "Involved in care, anyone talk to me about care? No they don't have time for that." Some relatives told us they had not been involved in the planning of their family relations care, one commented, "We haven't been involved in [Person's] care."

However one relative told us they were happy with the care plan for their relation, they told us, "[Person's] file notes are always up to date because I check them."

We saw that where care plans identified people required support for personal care, daily records were not always completed to show this had been provided. For example one person's charts did not include any entries recorded on two separate days to reflect they had received a wash. There were no records indicating when people had received assistance with toileting or had their incontinence pads changed. This meant staff would not be able to identify when a person had been to the toilet and if they needed to be assisted. This is especially important for people who cannot communicate their needs.

We observed one person in the lounge and they were requesting support to move back to their bedroom. Two members of the nursing staff were sat in the lounge area on their break and told the person that they would find a member of care staff to support them. We saw they had to wait for 15 minutes until care staff attended to their needs. We also observed another person in the lounge in the afternoon who looked anxious, they were unable to communicate very well and there was no call bell available for them to request

staff. We went to speak with them and they appeared to be trying to tell us they wanted the toilet. There were no staff around to respond and we went to find a nurse to advise them that this person required assistance. The nurse returned to assist the person.

Prior to our visit we had received information from relatives who told us that they did not feel people were taken to the toilet when they needed to be. One relative we spoke to during our visit told us, "[Person] doesn't like to drink a lot because she says staff take so long to take her to the toilet." Another relative told us their family member had been unwell, "[Person] had a stomach upset a while back and we mentioned to staff that she may need the toilet and was told 'she has a pad on'."

This was a breach of Regulation 9 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care

We spoke to the manager about these concerns and they informed us documentation would be improved to accurately record the personal care people should be receiving. They acknowledged that care plans needed to be improved to ensure that people received care that was centred around their individual needs.

Following our inspection visit the area manager informed us care plans were to be reviewed to ensure thorough assessments of people's needs were in place and the 'resident experience team' would be providing additional support and training to staff. They told us nursing staff would be instructed to support people with their personal care and the manager would be carrying out supervision meetings with staff to discuss the importance of addressing the concerns we identified. Charts documenting when people received personal care from staff would also be placed in people's rooms to monitor they received personal care when requested, or as recorded in their care plan.

During our visit we saw there was very little staff engagement in the main lounge and several people spent long periods without any interaction. Several people were cared for in bed due to their poor physical health and we observed one person had their bed positioned facing a wall with no source of interaction for them such as a television. We did see other people in their rooms watching television or listening to music and several people were reading.

The home had an activities co-ordinator who worked five days a week. They told us they were concerned that their role was diminished by the amount of time often spent carrying out other duties, such as assisting with personal care and working in the kitchen. These duties included transferring people out of bed and into chairs, supporting people to eat and helping to serve drinks. When we first arrived at the home we saw they were taking fresh drinks to people in their rooms. They also told us on occasions they would be showing people around the home and running errands to the GP and local pharmacist. They commented, "I don't mind helping. They [people] rely on you for everything. People are often shouting for the toilet and there isn't the staff. As soon as you get in they want your attention because they are bored and lonely, but I am too busy doing basic needs to start my job."

We saw the activity worker engaged in some individual activities with people once they had completed giving people their drinks. This involved speaking with people about sports activities they enjoyed when they were younger. We saw they were highly motivated to support people with activities and they showed us a journal of activities they had carried out at the home. This included, fireworks for bonfire night and celebrations for Halloween. They also carried out creative tasks for Remembrance Day and Children in Need and had organised a Christmas fair. The home was in the process of getting ready for a summer fair. They told us funding activities for people was difficult as the budget for entertainments had been reduced. People and relatives were asked at meetings for suggestions about events. For example the upcoming celebrations

for the queen's birthday celebrations had been discussed at the last meeting.

Staff told us there were staff handover meetings between each shift when they would be informed of any changes in people's health so they could respond appropriately.

Information about how people could raise complaints was displayed on a noticeboard in the entrance hall of the home. We asked people if they knew how to make a complaint, one person told us, "I would speak to the manager if I was not happy about anything."

Relatives we spoke with told us, "We can go and tell the manager." We saw during our inspection that relatives attended the office to speak with the manager.

The manager told us all formal complaints received were recorded on to a 'tablet computer' so they were able to identify any emerging trends and take appropriate action. We saw there was a 'tablet computer' in the reception area which was available for anyone who visited the home to use. This could be used to request an appointment to speak to the manager and also to raise concerns and complaints. The manager told us they reviewed information entered onto the computer regularly and addressed any issues raised. Relatives we spoke to were aware of the 'tablet' but one commented, "There is a machine on the wall where you can give feedback but I couldn't put in what I wanted to say because the staff member was standing there."

The manager told us, "We do address day to day concerns but if families have concerns we always log this so we can evidence we have addressed their issues." They told us complaints were discussed with staff in group supervision meetings so they were aware of the concerns and the improvements required.

We saw thank you cards displayed in the main foyer, comments included, "Thank you all so much for the love, care and attention my mum received over the last seven years and especially for the last few weeks, helping her to pass away peacefully. I was particularly touched to hear you had all come and kissed her goodnight just before she died...It was always comforting to know she was in good hands." And, "Thank you so much for the tremendous care and attention that you gave our Dad. We will be forever grateful."

Another card read, "We would be pleased if you would pass on to staff our grateful thanks for organising such a lovely afternoon to celebrate [Person's] 100th birthday. She and the other residents really enjoyed the choir joining in the songs. The choir was a real treat. I know [Person] really enjoyed herself. It was pleasing to see such lovely, friendly and caring staff."

Is the service well-led?

Our findings

At our previous inspection in January 2015 we had found the provider was in breach of Regulation 16 and 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. They had not sent notifications of deaths, or incidents which affected the health, safety and welfare of people which occurred in the home. They had sent us an action plan outlining the improvements they intended to make and we found improvements had been made. Where we identified two notifications did not contain sufficient detail the provider had addressed this with the individual staff member.

The service had a registered manager in post. The registered manager understood their responsibilities and the requirements of their registration. For example they had submitted statutory notifications and completed the Provider Information Return (PIR) both of which are required by Regulations. We found, however that the information in the PIR was not an accurate assessment of how the service operated. For example it stated that care plans were person centred and took into account people's past and present wishes on how they liked to receive their care.

We asked people if they felt the service was well led, they told us, "I think the home is well run, I've heard it's one of the best." Another told us, "It appears to be well led, you can't foresee staff ringing in sick and the staff all pull together, its good teamwork." Relatives we asked told us, "Yes it is well led." Another told us, "[Person] has thrived, absolutely thrived here, when she arrived she weighed 6 stone, with loads of sores. The staff carried out experimental treatments until they found one that worked. I would shout from the rafters how good this place is."

However one person commented, "They don't do a lot for the people here. I like this place...but it's not run properly."

We spoke with the area manager on the day of our inspection visit to express our concerns over our findings and they were open and transparent about the challenges the home faced. They had only recently been appointed to their role following the resignation of the previous area manager. They told us, "I had already identified there are improvements that needed to be made. I intend to see improvements are made and standards maintained."

They acknowledged the home had many challenges and prior to their recruitment into the post there had been no sustained area managerial oversight to support the manager and staff. They immediately responded to our concerns and told us support would be offered to the home by the providers 'resident experience team'. Following our visit the provider appointed a new managing director and they had arranged a meeting with us and the local commissioning team to discuss the concerns we identified.

Staff spoke warmly of the manager, comments made were "She is brilliant." and "Supportive, but her hands are tied." Staff told us they felt the provider did not support the home enough and one told us during a difficult personal period the manager had been very caring and supportive but they did not feel supported by the provider. Staff felt the manager was trying hard to address issues about staffing numbers but they

were not supported by the senior managers. We observed the manager was kind and caring to staff, and people at the home.

The manager had registered with us shortly before our inspection and told us they were committed to making improvements in the home and acknowledged that staff were under pressure to provide the care people required. They told us, "I have a fabulous bunch of carers and they are trying hard to meet the dependency needs of people." They told us the deputy manager was due to resign their position but they would be continuing to work at the home as one of the nurses. They went on to say the provider would be looking to recruit a new deputy to maintain the level of management the home required.

The provider carried out audits to monitor the quality of the service provided. This was carried out on a 'tablet computer' and there was a timetable indicating audits that needed to be carried out by the manager on a weekly and monthly basis. These included checks on medicines, falls analysis, and skin damage. Random checks of care plans were conducted and staff, people who lived at the home, relatives and any visiting healthcare professionals spoken with to see if they had any concerns. We asked the registered manager what happened at weekends and they told us the checks were still conducted by the staff on duty. The area manager told us they monitored the system to ensure these checks were being carried out. Whilst we saw audits were being undertaken they had not identified all of the concerns we found.

We received mixed responses from people when we asked whether communication was good and if they felt informed and involved in the running of the home. One person told us, "As far as I know I think they have residents meetings but I haven't seen any minutes." We saw minutes from the last residents and relatives meeting which was held in April 2016. Relatives had been informed about the 'tablet' computer available for them to provide feedback. Relatives who had concerns about their family members' medical condition were asked to speak with the nursing staff or manager who could answer their questions.

The manager told us they were keen to improve communication and share information with people who lived at the home and relatives and had organised another meeting to be held in July. We asked how they listened to the experience of people who were unable to attend the meetings particularly people who remained in their rooms. The manager told us as part of their quality of life audit system a senior member of staff would visit people to discuss if they had any concerns or issues.

Negative responses given by people showed as 'red' on the system and this gave a visual cue for the manager to address the issues. If these were not addressed, the area manager would follow this up directly with the manager to establish why actions had not 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 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 9 HSCA RA Regulations 2014 Person-centred care
Diagnostic and screening procedures	9(1) People did not always receive care and treatment that met their needs and preferences.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Diagnostic and screening procedures	11(1) Where a person lacked capacity to make an informed decision staff did not act in accordance with the requirements of the Mental Capacity Act 2005.
Treatment of disease, disorder or injury	
	11(2) Staff were not familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Diagnostic and screening procedures	18(1) There were insufficient numbers of suitably qualified, skilled and experienced staff to meet people's care and treatment needs.
Treatment of disease, disorder or injury	