Kidderminster Care Limited

# Brownhills Nursing Home

## Inspection report

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27 November 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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

Our inspection took place on 22 and 27 November 2017 and was unannounced. We last inspected the service on 15 February 2017 and found the service requirement improvement across four of the key areas we inspect, with a rating of 'good' in the question, 'Is the service responsive?' This is the fifth consecutive time the service has been rated Requires Improvement.

Brownhills Nursing Home 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.

Brownhills Nursing Home accommodates 50 people in one adapted building. At the time of the inspection there were 48 people living at the service.

There was 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.

Staffing levels, staff sickness and the deployment of staff across the home could not ensure that people's needs were met in a timely manner. The combination of new and agency staff meant not all staff were fully aware of the risks to people on a daily basis. New staff were provided with an induction to prepare them for their role but systems were not in place to ensure agency staff received the same level of information in order to meet people's needs.

Staff were aware of their responsibilities to keep people safe and had received training in how to recognise abuse and respond to any concerns raised.

People told us they felt safe. People were supported with their medication and were noted arrangements in place for the management of medication was safe. There were systems in place to reduce to risk of infection but these were not always followed by staff.

Where accidents and incidents took place, lessons were learnt and actions taken to reduce future risks.

Pre-assessments of people's care needs took place prior to people moving into the home. Staff were provided with training in order to meet the needs of the people they supported safely and effectively.

People were supported to have enough to eat and drink to help maintain a healthy diet. A variety of healthcare services were available to people in order to meet their needs. Staff were aware of people's healthcare needs and referrals were made to a variety of healthcare services in order to meet people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were not always treated with dignity and respect. The approach to care was task led and people could not be confident that they would consistently be treated with kindness and compassion. People were supported to make choices regarding their daily lives and were supported to access advocacy services.

Staffing issues and the poor deployment of staff across the home continued to have an impact on care delivery. Staff recognised the positive changes introduced by the registered manager but were concerned that staffing levels across the home required improvement. The provider and registered manager were actively looking for solutions to improve staff recruitment and retention.

The registered manager worked in partnership with other agencies in order to improve care delivery. Systems were in place to obtain feedback from people living at the service.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

People's needs were not always met in a timely manner due to the lack of and poor deployment of staff. A lack of staff awareness was seen to increase the risk presented to some people. Staff had received training in how to safeguard people from abuse. Where incidents and accident took place, lessons were learnt and action taken.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

New staff were provided with an induction designed to prepare them for their role but systems were not in place to provide agency staff with the same level of information. Staff felt supported and well trained. People were supported to maintain good health and had access to a variety of healthcare services to meet their needs. People's consent was obtained prior to them being supported.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People were not always supported in a timely manner that ensured their dignity was respected and promoted. There was a task led approach to care which lacked care and compassion. People were involved in decisions regarding their day to day care and had access to advocacy services.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Not all staff were aware of people's care needs and what was important to them. Activities were available for people to

participate in. Where complaints had been received, they were investigated and responded to appropriately.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

Staffing issues and the deployment of staff continued to require improvement. Staff felt supported and encouraged by the improvements that were being introduced by the registered manager. The service worked in partnership with other agencies to improve people's health and wellbeing. Audits were in place to assess the quality of care provided.

# Brownhills Nursing Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 22 and 27 November 2017 and was unannounced. The inspection was carried out by two inspectors.

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.

Prior to the inspection, we were made aware of some concerns regarding care delivery at the home and we used this information to form part of our planning for inspecting the service. We reviewed other information we held about the provider, in particular, any notifications about accidents, incidents, safeguarding matters or deaths.

We asked the local authority for their views about the service provided. We used the information that we had gathered to plan what areas we were going to focus on during our inspection. We spoke with nine people who lived at the service, five relatives and two healthcare professionals. We spoke with the registered manager, who was present on the second day of the inspection, the provider, the clinical lead, the area manager, four members of care staff, the activities co-ordinator, the administrator and the chef.

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 reviewed a range of documents and records including the care records of five people using the service, eight medication administration records, two staff files, training records, accidents and incidents, complaints systems, minutes of meetings, activity records, surveys and quality audits.

Requires Improvement

# Is the service safe?

## Our findings

We received many mixed comments regarding the staffing levels in the home, from both people living in the home, relatives and staff. One person said, "I think there's enough staff" and another said, "Staff respond to bells, have to wait a bit sometimes but it's ok." At relative said, "No, there's not enough staff; today is abysmal, running themselves ragged, I don't know where anyone is" Another relative said, "There are times, especially at the weekend when they seem to be short of staff, but generally there seems to be sufficient numbers." Staff spoken with were concerned about the staffing levels and the impact this was having on care delivery and staff morale. One member of staff said, "There's not enough staff. We took on people who need one to one care and it took us away from other clients." They went on to explain that they had been a lot of staff sickness which was having an impact across the home and told us, "Some agency staff are incompetent. I prefer to put myself out, I'm not here for anyone but the clients. I was here yesterday and worked upstairs and down, and it does tell on you." We observed that support was task focussed as opposed to person centred.

We observed staff were not deployed effectively to meet the needs of the people using the service. We observed incidents which indicated that staffing levels were not sufficient to meet people's needs and ensure people were kept safe and protected from harm. For example, in one lounge area, we saw two people were continually trying to get up and had requested to go the bathroom. There was only one member of staff present, who was constantly telling one person, "You can't go [to the bathroom] yet, you'll have to wait for staff to come and help" and repeatedly telling another person, "Can you just stay there" every time the person tried to get up, adding, "I know you want the toilet but I can't take you yet." Over a period of 30 minutes both these people were constantly being asked to sit back down and wait for staff to arrive to support them. A relative commented, "Sometimes there is only one member of staff and some ladies are trying to get up to go the bathroom." We observed one member of staff run across the room to get to a person who was at risk of falling and who was trying to get up and walk. A relative observed; "I'm worried as there are two people who wander. There is always someone in the lounge but they use the activities co-ordinator to watch people whilst they nip from one place to another; when [registered manager's name] isn't here, things don't run as smoothly; it's not normally so disorganised." A member of staff said, "Sometimes it is really frustrating; some people want to go to toilet they have to wait for staff to be available, sometimes people complain but we have to tell them they need to wait." We observed there was a lack of organisation which meant that people's care needs were not met in a timely manner and people's ability to freely move around the home was restricted. We observed similar incidents on both floors of the home.

We were told that staff were instructed not to leave the lounge area without ensuring another member of staff was present. However, we noted on two occasions people were left in the lounge with no staff to support them, on one occasion for ten minutes. This meant that the risk to those people who were at risk of falling increased at this time. We found other examples of staff not being deployed effectively and people being kept waiting, for example; we found one person in their room with no access to their call bell. They told us staff had hoisted them and put them in their wheelchair and then left them without taking them to the bathroom. They told us this had not happened before, but were upset at being left and what they

considered, 'forgotten'. We rang the buzzer and staff responded within minutes and then supported the person to the bathroom. We observed another person call out, "Help, come back" to staff. This was ignored and eventually the person sat back in their chair and closed their eyes.

We saw there was a dependency tool in place to assess the staffing levels in the home. The registered manager told us that the number of nurses on shift had recently been increased from one to two but only Monday to Friday. They told us they considered the additional nurses were required in the week to assist with GP calls and other healthcare visits and appointments which did not take place at the weekend. Despite the dependency tool being in place, people commented that staffing levels were not adequate, particularly at weekends. One member of staff told us, "We need more staffing, we have two people who are very restless and the numbers of staff supporting them are not enough and this puts people and staff at risk. They need staff to sit with people and you end up running from one to another to make sure they aren't falling."

This is breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider had failed to ensure there were sufficient numbers of suitably qualified, competent and skilled staff who were effectively deployed to meet people's care and welfare needs.

The provider told us in their Provider Information Return [PIR] that the last infection control audit of the service had received a score of 90%. We saw that cleaning schedules were in place and were monitored through daily checks and audits. Staff were observed to follow appropriate infection control and prevention practice, for example, by using personal protection equipment [PPE] when providing support. However, we noted an incident where a person had become incontinent and was sitting in their wet clothes. Staff took the person to their room to get them clean and changed but then returned them to the lounge for them to sit on the cushion they had originally been sitting on which had not been wiped clean.

We saw that the risks to people were assessed and reviewed in order to provide staff with the most up to date information regarding people's needs. A whiteboard was on display in the staff room which provided staff with a snapshot of the risks to each individual living in the home. However, not all staff spoken with were aware of the risks to the people they supported. An agency member of staff told us, "I've not had an induction, so I'm not sure about people; I have to get staff [to advise]." The combination of new and agency staff in post meant that people were supported by a staff group that were not always fully aware of their needs. For example, a relative told us, "If there is a change of carer they don't always thicken drinks. I came in this morning and they hadn't put thickener in the drink." Thickeners are prescribed by GPs and are put in drinks for people who are assessed as at risk of choking. The relative told us this had happened before and they had raised this with staff. We observed the activities co-ordinator was included on the rota to work alongside care staff [providing care support] prior to commencing their duties as activities co-ordinator, in order to assist staff during the morning period. We saw that they were left in the lounge on their own to observe people whilst staff were elsewhere in the building. They told us, "I am helping out today, I know some people have thickeners so I'm asking staff how much they have, how many scoops. It's written down somewhere." This meant that people were at risk of not receiving fluids in a consistency that reduced the risk of choking as not all staff were aware of the information or where to access it."

People told us they felt safe. One person said, "They [staff] are looking after me, it's very nice, feels safe" and another said, "I feel safe, yes I do, been here a while." A relative said, "I can only speak from what I can see, [person] is safe" and another commented, "I feel [person] is safe, my only concern is the layout of the building; the stairs concern me." They told us they hadn't raised this concern with the registered manager, but they intended to do so.

People were supported by staff who were aware of their responsibilities to raise and act on any safeguarding concerns that came to their attention. A member of staff told us that if they came across a concern, "I would see if it had been reported and if not I would document it and raise it." The deputy told us, "It's everyone's responsibility to [report concerns]. Staff are quite good and any minor thing and they will tell the nurses." We found that details of accidents and incidents were recorded in a handover book. However, we found some of these events, such as skin tears and unexplained bruising, were recorded inconsistently and we were unable to evidence where actions had been taken in all cases. We reported this to the registered manager who told us she would investigate and report back to us. Following the inspection the registered manager was able to confirm that through her own investigations, she had found that actions had been taken to report and act on the concerns raised. We saw where accidents and incidents took place, they were analysed for any trends and where appropriate, lessons were learnt. For example, we saw following a review of incidents, it was identified that staff required additional training in the management of behaviours that may challenge and this training was put in place.

We saw prior to staff commencing in post, they were required to provide two references and complete checks with the Disclosure and Barring Service (which provides information about people's criminal records). Staff spoke with confirmed this. This meant people were supported by staff who had been safely recruited.

One person told us, "I get my medication when I need it." We observed medication was stored and secured safely. We looked at the medication administration records for seven people. We saw that the amount of medication given tallied with what was in stock. We noted for those people whose medication was to be administered 'as required', protocols were in place providing staff with the circumstances in which the medication should be administered. Staff had received training in how to administer medication and told us their practice was regularly observed to ensure they were competent to administer medication. We noted that recent audits of medication conducted by the pharmacy supporting the service were positive and staff were complimented on their skills and care when supporting people with their medication.

Requires Improvement

# Is the service effective?

## Our findings

People told us they were happy with the care they received. One person said, "[Deputy's name] is a good nurse" and another said, "They [care staff] are marvellous, each and every one. I watch what they do." A relative told us, "We haven't got any concerns about care, I think [person] is being cared for wonderfully here. They were always asleep in the last place" and another said, "I visit daily and I'm very happy with the care." We noted that people's needs were assessed and considered how people's health and well-being should be met. Care records seen contained information about what was important to people, for example, if people had any particular religious needs, preferred a male or female carer or followed any particular diets due to their beliefs.

Two staff spoken with told us they were happy with the induction they received. One member of staff, who had previously worked in care, told us, "I spent six hours with the manager and had two days shadowing [other staff]; it was enough for me." Another member of staff told us they felt supported by the registered manager during the induction and that they had been instructed not to hoist anyone until they had received their training, adding, "If I'm not sure about anything I will ask, I don't want to make mistakes." Other staff raised concerns regarding the effectiveness of the induction in ensuring new staff, particularly those who had not worked in the care sector previously, were fully prepared for their role and cited this as a possible explanation for the poor retention of staff.

People told us they considered staff to be well trained and had no concerns regarding their ability to support them effectively. Staff told us they felt supported in their role. A member of staff said, "[Registered manager's name] does supervisions and appraisals, I can't remember when I last had supervision, possibly April, but I can always approach her if I need to see her." Systems were in place to provide staff with the training and support they required. A member of staff told us, "Training is appropriate, but more training would enhance what we do. I have asked for peg care training and they are looking into it." Staff told us, and we saw that the registered manager had provided staff with a number of opportunities to carry out additional training.

One person told us, "I'm having egg and tomato for breakfast" and a relative commented, "[Person] has a good appetite, and loves their food." The provider told us in their Provider Information Return [PIR] that the service catered for individual diets and any concerns regarding people's dietary needs were referred to the dietician and we saw evidence of this. We spoke with the cook who had a comprehensive knowledge of people's dietary needs and preferences. Where specific diets were requested, they were catered for. Where people were at risk of choking, meals were pureed. The cook told us they wanted to present pureed food using particular food moulds to make meals appear more appetising and had requested these items. We saw there was a six weekly menu plan which had been put together and the cook had spoken to people individually to check that they were happy with the meals on the menu. Meals were fortified for those people with poor appetites to enable them to put on weight. A relative told us, "On the whole, girls [care staff] are lovely, smashing, [person] is putting weight on." Activities were in place to encourage people to eat a variety of foods, for example, on a Friday, fresh fruit was cut into small pieces and people were encourage to try different fruits as a way of getting a healthier diet.

The registered manager and staff group worked alongside other agencies to provide people with the care and treatment they required. We spoke with a nurse practitioner who visited the service on a weekly basis. They told us the registered manager had made a number of improvements in the last 12 months. We saw arrangements were in place to ensure the nurse practitioner was provided with the most up to date information about the people they were supporting in the home. They told us communication between themselves and the home was good, adding, "They [care staff] are doing what they should be doing. Whatever I ask them to do they do." This meant arrangements were in place to share and receive information with other professionals that were effective in delivering care, support and treatment.

People were supported to access healthcare services and receive ongoing healthcare support. Relatives spoken with could not fault the response to people's healthcare needs. One person told us, "If they feel a doctor is needed, a doctor there is. I am happy with the service I receive." A relative described how their loved one had become unwell in the early hours of the morning. They told us, "They [staff] were excellent; they contacted the ambulance and then rang me. I was impressed with the speed they reacted to the situation. I cannot fault them" and another relative said, "Since [person] has been here, they have not been unwell." We observed a person tell a member of staff they were in pain. The deputy spoke to the person, offered reassurance and arranged for a urine test to be carried out. The person was seen later in the day by their GP.

We noted the layout of the building did not provide an environment that was easy to navigate. However, new signage had recently been placed around the home to enable people to locate lounges and their bedrooms. Communal lounges on both floors were light and airy, but had little in place to stimulate people. One relative commented, "The lounge is very clinical, it feels very cold and has not got a lot going for it." The registered manager told us there were plans in place to improve the environment for people living at the service.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We observed staff obtaining people's consent prior to supporting them, for example, we saw one member of staff ask two people if they would prefer to sit in 'comfy' chairs rather than sit at the table. Staff spoken with had received training in MCA and DoLS and we noted that family members were given the opportunity to be involved in DoLS applications prior to them being submitted. A member of staff told us, "People have DoLs in place to deprive them of their liberty, they haven't got capacity to make their own decisions and have [staff] have to help for their own safety" but another member of staff was unsure who had a DoLS in place and required prompting on the subject. This inconsistency in the understanding of this subject meant that the registered manager could not be confident that all people in the home were supported in line with the principles of the MCA. We discussed this with the registered manager who told us additional training had been offered on this subject by the local authority and she was in the process of arranging this.

Requires Improvement

# Is the service caring?

## Our findings

Staff did not always consider the importance of people having access to specific aids or adaptions that would maintain their dignity. A relative told us, "Staff as individuals are nice people, but not pro-active" and went on to provide us with an example of this in relation to their loved one. Staff spoken with were able to describe to us how they treated people with dignity and respect and a relative told us, "Staff treat [person] with dignity and respect." However, our observations did not always reflect this comment. The poor deployment of staff across the home meant that people's care needs were not always met in a timely manner. For example, one person told us they had been calling out to staff to take them to the bathroom and staff had not responded. They told us, "I am wet, I need changing, I am sorry, no one has changed me, it's disgusting. I am wet and uncomfortable." A relative told us, "They [staff] keep [person] clean, will cut their nails, but not the finer points, they don't always mop up much after dinner, I'm always having to get a wet wipe and wipe around their mouth."

We saw one person was wheeled into a corridor. The member of staff realised the person's hair hadn't been brushed and then started to brush it in the middle of the corridor, without speaking to the person whilst this was happening. We observed staff support a person using a hoist. There was no interaction during this process, no reassurance or explanation as to what was happening. We observed whilst another person was being hoisted, staff had failed to arrange their clothing to maintain their dignity during this process. This resulted in the person exposing themselves to a member of staff. We saw another person being supported by a member of staff to eat their meal, but part way through this, the member of staff got up and walked away to do something else, without speaking to the person or providing them with an explanation. These incidents alone meant the registered manager could not be confident that people were consistently treated with dignity and respect.

This is breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider had failed to ensure people were treated with dignity and respect

A relative told us, "Staff do talk to people but usually only if asked about something, they don't generally talk to them." Another relative said, "There are some genuinely nice members of staff, but some staff will have a break and leave other staff on their own. There appears to be a culture; instead of 'let's not have a break let's provide care' everything stops for the break." We also observed this. For example, at one point during the day, we noted staff sitting in the staff room whilst call bells were ringing. Staff did not respond to this until the inspector mentioned the call bell ringing. We also observed a number of occasions where staff failed to acknowledge and engage with people. For example, we observed occasions where staff sat in communal lounges alongside people, or opposite them, but did not engage in conversation with people. People told us that staff who supported them were kind and caring. One person said, "Staff are kind and caring, I am happy with the care" and their relative agreed with this statement. We observed some staff taking the time to speak to people as they walked by and ask how they were. We noted the deputy took time to chat to people, respond to them and offer comfort and support, in a kind and caring manner.

Two relatives spoken with told us they could visit at any time and felt welcome in the home. Another relative

told us, "It would be nice to be offered a cup of tea when I arrive, one carer does this but none of the others do. It's a basic common courtesy."

At our last inspection we observed people's care records were not always kept securely. At this inspection, we found that records were kept in a secure lockable cabinet in the staff room, which was kept closed when the room was empty.

One person told us, "I can get up when I like and have a bath or shower. You have to wait your turn sometimes. I don't like water in my face and they try not to do that." Another person said, "I am happy here, I get up around 6.30am, it is my choice, I try to do things for myself, I make my bed and I call the carer if I need help. I go to bed when I want there are no restrictions I have plenty of cups of tea; I have no grumbles."

We observed one person being supported to maintain a level of independence. Two members of staff were seen to encourage the person to push themselves to stand up and the person responded positively to this encouragement.

We saw information was on display regarding advocacy services that were available for people to access. Although no-one at the home currently used an advocacy service, the registered manager told us these services had previously been used and was aware of how to access them on people's behalf. An advocate is an independent person who can provide a voice to people who otherwise may find it difficult to speak up.

Requires Improvement

# Is the service responsive?

## Our findings

One person told us, "I have been asked to sign care plan paperwork." A relative described how they had spent time with the registered manager, putting together a care plan that reflected their loved one, their care needs and what was important to them. They told us, "My daughter filled in a sheet with all [person's] idiosyncrasies and about the family." Another relative told us, "I think I saw a care plan and signed it at the start. No reviews but when I do come they will talk to me." Other relatives confirmed they had not been involved in formal reviews of their loved one's care, but that the registered manager was accessible. One relative added, "I have had a couple of meetings with [registered manager's name] since [person] came in." Care records seen held detailed information regarding people, their family background and history, providing detailed information about each individual. However, not all care plans reflected people's involvement and not all staff were aware of the content. When we asked one member of staff about a person, they could only tell us, "[Person] is a nice lady." Other staff, who had been at the service for a number of years, had a comprehensive knowledge of the people they supported and what was important to them, for example one person liked honey in their tea and another would not go anywhere without their handbag.

People spoke positively about the activities co-ordinator and the role they played in the home. One person told us, "I'm going to do some Christmas cards, [activities co-ordinator's name] is arranging it." Another person said, "Nothing is too much trouble for [activities co-ordinator's name], this is a nice place to live, I am happy here." Relatives were equally as complimentary. We observed arrangements were made for afternoon tea and people were offered a variety of cakes which they clearly enjoyed. The activities co-ordinator told us they made the effort to speak to every person in the home every morning and held a comprehensive knowledge of the people living in the home. For example, they were aware that if one person became distressed, they would often find comfort in looking at a photograph of their loved ones. Another person said they missed their dog and arrangements were made for pet therapy to visit the service. Activities available included a number of visitors to the service including pet therapy, fitness classes, singing and painting.

One person said, "All staff are very good, you can't fault them" and another said, "[Registered manager's name] is very good, I've had few little complaints but they have been dealt with. I've no concerns." Relatives spoken with told us they had no complaints and we received the following comments; "I have nothing to complain about, they [person] are doing well, it's nice and warm as well" and, "Can't complaint about general standards of care, [person] is never ill, there's never been a smell in the home and it appears to be a clean environment." Other people told us they had no complaints about the service but were aware of who to speak to should they have any concerns. We saw that there was a complaints process in place to record and investigate any complaints received. Where complaints had been received, they were investigated and responded to appropriately.

We saw that systems were in place to support those people who were at end of life care. A visiting healthcare professional described how staff had supported at person who was receiving end of life care. They told us, "They [staff] were good, they managed to keep [person] out of hospital, which was their wish. They managed

it really well and made sure they had their medicines administered appropriately."

Requires Improvement

# Is the service well-led?

## Our findings

We saw that despite a number of systems and processes in place to ensure the service operated effectively and complied with the requirements of the regulations, this was the fifth consecutive time the service had been rated as Requires Improvement. The findings of this report and evidence obtained in favour of breaches with regard to staffing and treating people with dignity and respect, meant that the service was not improving in all questions asked.

During the last inspection we found some improvements had been made around staffing levels. Despite this and the use of a dependency calculator used to determine how many staff were required, at this inspection, concerns remained regarding staffing levels and the deployment of staff in the home. From our observations we noted that the systems in place to deploy appropriately skilled and qualified staff across the home were not fit for purpose and the registered manager had not identified this. We saw the daily staff allocation sheet in place identified a number of tasks staff needed to complete whilst on shift, such as responsibility for tea trolleys, taking people for showers and removing yellow waste bags. We were told the nurse on shift and senior care were responsible for the ensuring all 'jobs' were completed whilst on shift. This meant that shift allocations were task based, not responsive to people's needs.

Staff also queried the judgement of arranging for two people to be admitted to the service, both with high dependency needs. A member of staff said, "We need to get things right before we bring more people in. I have raised it with the provider. It is a good home, but we need staff who understand what they are doing." We observed when new people were admitted to the home, their dependency levels were assessed, but staffing levels and the deployment of staff did not change, resulting in people's needs not being met in a timely manner. We saw that information was not always made available to staff which placed people at risk, for example, information regarding people who were at risk of choking.

The registered manager told us they had oversight of the service through their daily walk rounds and conducted a number of early starts in order to sit in on handover meetings and meet night staff. However, despite this, the registered manager had failed to identify a number of areas of concern that had been identified during the inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014, Good governance.

We saw that the combination of staff leaving and difficulties in recruiting and retaining staff was leaving existing staff feeling under pressure to cover absences. This coupled with the use of agency staff who were not familiar with the people living at the home, had an impact on staff which resulted in higher levels of staff sickness. A member of staff reflected on this situation and told us, "If staff look at the rota and see they are the most senior on shift and the rest are agency, they will ring in sick."

Staff had their own opinions when it came to recruitment and retention of appropriately qualified staff. Some felt new staff coming in had unrealistic expectations of care and many had left because of this. Others

felt the induction process did not provide staff with the skills and support required to meet people's needs. One member of staff said, "The induction process isn't the best. Just because you have worked in care before doesn't mean you know everything." The registered manager told us, "All basics are covered in the first week of induction and at the end of the three months' probation we'll have an appraisal. You need to nurture your new staff and I'll speak to them during that time." We discussed recruitment and retention with the provider and the registered manager, they described their frustrations regarding this and were determined to look for solutions when it came to recruitment and retention of staff.

We discussed staffing levels and the effective deployment of staff with the provider and the registered manager. We provided them with numerous incidents to evidence our concerns, not only regarding people's care needs not being met, but there being enough staff deployed to ensure people were treated with dignity and respect at all times. We described an incident where a member of staff responded to a person's request for a biscuit but then ignored them and told the inspector they couldn't leave the room to get a biscuit until another member of staff arrived. We raised this with the provider who responded with the details of the number of staff but they had not adequately considered the deployment of staff across the home to ensure people's needs were being met.

We received a mixed response from staff with regard to the registered manager. No staff doubted their commitment to the service and recognised the changes being introduced. However, a number of staff commented negatively on the registered manager's approach. One member of staff said, "[Registered manager's name] speaks to staff inappropriately sometimes. There's a way and a manner when speaking to people. I can't fault [registered manager's name] but the issue is more about their manner." Others felt staff were not always supported and some staff told us they found the registered manager difficult to approach. We received the following comments from staff; "If you work under duress, ie short staffed, people don't work well", "It's hard work and a lot of people don't like hard work, we are not here for us but for them" and "There's not a lot of ' thank-yous'". Despite these comments, we saw that the registered manager had introduced a 'Champion of the month' to help staff 'feel appreciated and give them value'. One member of staff said, "[Registered manager's name] is really trying her best" and another said "[Registered manager's name] is trying to introduce change. Since they have been here they have done a lot." Other staff also spoke positively about the registered manager and the improvements they had introduced, for example allocating two staff on the morning shift to assist with supporting people to have their breakfast.

The registered manager discussed the challenges they had encountered when they took on the role. They told us, "When I came, there were staff I wasn't impressed with, it's taken time, sometimes people don't like it when you tell them how to do things." We saw that a staff handbook had been produced since the last inspection and was in the process of being rolled out to all staff. Relationships had been developed with healthcare professionals in order to meet people's healthcare needs and keep people safe. The registered manager told us they felt fully supported by the providers adding, "I have a good working relationship with both of them and know I've earnt their respect and it works both ways. Everything I have asked them for I've had." They told us and staff confirmed, that additional staffing had been requested following a team meeting, but a member of staff said, "I do feel listened to by the manager but I don't feel what we want will be dealt with. We asked for additional carer at night and got that and nurse in day and got that but only Monday to Friday."

We received a mixed response from people regarding the service. On the whole, people were positive, but concerned about staffing levels. Other comments received from relatives included, "[Registered manager's name] is well organised, approachable", "[Registered manager's name] is a nice lady to talk to, though I don't see much of her walking the floor", "I would recommend the service, it's clean, well kept, staff appear well trained, I've observed people being lifted properly. Never seen anything untoward."

The registered manager discussed their plans for supporting the clinical lead to develop their role and told us, "We work well together and I think we are a good team." The clinical lead told us they felt fully supported by the registered manager and were fully on board with their vision for their service, to improve the quality of people's lives at the home.

We saw there were a number of audits in place to assess the quality of the service provided and drive improvement, for example, medication audits, analysis of accidents and incidents and environmental checks. The registered manager worked closely with other agencies in order to improve safer care for people. For example, the provider told us in their Provider Information Return [PIR] that they were involved in a project supported by the CCG [Clinical Commissioning Group] designed to reduce the number of falls people suffered and we saw evidence of this. Staff spoke positively of the benefits of this project and the introduction of the whiteboard in the staff office, detailing people's care needs.

People confirmed that they had been asked to provide feedback on the service in the form of surveys and we saw evidence of this. A relative told us, "I would recommend it. It's quite homely and [person] seems happier."

The provider had notified us about events that they were required to by law and had on display the previous Care Quality Commission rating of the service.

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<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider had failed to ensure people were treated with dignity and respect. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure there were effective systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people living at the home. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had failed to ensure there were sufficient numbers of suitably qualified, competent and skilled staff who were effectively deployed to meet people's care and welfare needs. |