St. Cloud Care Limited

Stowford House Care Home

Inspection report

Faringdon Road
Shippon
Abingdon
Oxfordshire
OX13 6LN

Tel: 01235538623
Website: www.stcloudcare.co.uk

Date of inspection visit:
05 December 2016
08 December 2016

Date of publication:
18 January 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Stowford House Care Home over two days. The first visit was on 5 December 2016 and was unannounced. We returned to complete the inspection on 8 December 2016.

Stowford House Nursing Home is registered to provide residential and nursing care for up to 51 older people some of whom are living with a dementia. At the time of this inspection, 48 people were living at the service. There were three vacancies at the service.

The service was previously inspected in November 2015 and we identified the service was not meeting two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not always administered as prescribed. We also identified that food was not served and maintained at the right temperature for the whole meal. People were not being supported to eat and drink where necessary. Following the inspection, the provider sent us an action plan, which detailed how improvements would be made. During this inspection, we did not see adequate improvements and also identified more concerns.

There was a registered manager in place. 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. They were supported by a deputy manager and regular visits from the provider's regional manager and a compliance manager.

Before the inspection, we had received a number of concerns about the staffing levels and the impact this was having on people receiving safe and effective care. We found there were not enough staff on duty on the day of our inspection. People and their relatives reported that people had to wait for an unacceptably long time before their needs were met. The provider was using a dependency level tool to calculate how many staff were needed to care for people. This was not evidenced as meeting the needs of people and the low staffing impacted upon most areas of the inspection.

People's medicines were not safely managed and not always administered as prescribed. We found gaps on the Medicine Administration Record (MAR). Records did not demonstrate clear guidance for staff in relation to medicines or topical creams.

Risks to people's safety had not been ensured. Clear plans to minimise and manage risks were not in place. Not all information was up to date and clear in the risk assessments meaning staff would not be able to take all necessary steps to promote people's safety.

Staff generally felt well supported but we found minimum records of any meetings such as one to one meetings and annual appraisals. Some staff felt there was low morale due to the workloads associated with low staffing levels. A range of training was arranged to increase staff's knowledge and help them to do their

job more effectively.

People were not always supported to ensure they had adequate nutrition and drinks. The quality and quantity of food and assistance required were not adequate. People did not always get the food they had chosen.

People were supported to access a range of services to meet their health care needs.

People found staff to be caring but people's dignity was not always protected. People were not assisted as often as they needed to be and this meant they often had to wait in undignified conditions until assistance was available. Staff were rushed and did not have time to spend with people.

Care plans were not always up to date which meant staff could not respond appropriately to people's needs or provide care in a person centred manner. Information stated care needed to manage falls and wounds but these people no longer had these needs. Records recording food and fluids was not completed consistently and was done both electronically and on paper. This meant there was not a clear system for monitoring people's food and fluid intake.

There was a complaints system in place. However, people and relatives had little confidence that complaints would be resolved to their satisfaction. Where areas for improvement had been discussed with people and their relatives the resulting actions had not always been effective in maintaining an improvement.

There were a range of systems to assess and monitor the quality of the service. However, not all were effective in identifying and addressing shortfalls. Accidents and incidents were being analysed yet action to minimise reoccurrence was not always sufficient.

Relatives and staff did not feel confident that the registered manager took on board all actions necessary to improve the service. We had many concerns raised before, during and after the inspection about staffing levels impacting on all areas of people's safety.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The overall rating for this service is 'Inadequate' and therefore the service in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel their provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we re-inspect and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff to meet people's needs effectively at all times.

Risks to people's safety were not being adequately identified and addressed.

Equipment in use was not always used correctly in line with guidance.

People's medicines were not safely managed or consistently administered as prescribed.

Safe recruitment practices were in place.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have a good understanding of the Mental Capacity Act 2005.

People were not assisted to eat to ensure they received sufficient food and drink. People and their relatives did not feel the food was of good quality.

People were supported by a range of health care professionals as required.

Training had been undertaken but not all staff felt fully supported.

Is the service caring?

Requires Improvement

The service was not always caring.

Most people and their relatives were complimentary about the staff team but felt staff were not getting the support needed to offer care and time to people.

Staff were knowledgeable about promoting people's rights but not all care demonstrated dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always up to date to ensure people's care needs were still accurate.

People and their relatives did not feel their complaints were being acted upon.

A range of social activities were provided.

Is the service well-led?

Inadequate

The service was not well led.

Insufficient action had been taken to address and maintain improvement in relation to the previous identified breaches in regulation.

Whilst there were a range of audits to monitor and assess the quality of the service, these were not fully effective, as shortfalls were not being addressed.

People, relatives and staff did not have confidence in the management and leadership of the home.

Stowford House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 8 December 2016 and the first day was unannounced. The inspection team consisted of two inspectors, a specialist professional advisor who was a nurse and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered provider had not submitted their provider information return (PIR) as we had brought forward the date of the inspection. The PIR 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.

Before our inspection, we reviewed the information we held about the service and information from the local authority safeguarding and commissioners.

Over the course of two days we observed the care provided to people who used the service. In order to gain people's experiences, we spoke with seven people who used the service and nine relatives. We also spoke to the management team comprising of the chief operating officer, compliance manager for St Clouds Care and the registered manager. We spoke with three nursing staff, a senior care worker and 10 members of staff.

We also reviewed four staff records, recruitment records, and the training and supervision matrix for staff. We looked at six care records including food and fluid records. We also looked at the medicine and consent information on five care plans. We also reviewed other records related to the management of the service.

Inadequate

Is the service safe?

Our findings

When we inspected in November 2015, the provider had not ensured people always received their medicines as prescribed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan, detailing how they would address the shortfalls.

At this inspection, we found medicines were still not being managed safely. We saw that there were gaps on the Medicines Administration Record (MAR) where a signature should have been to confirm the medication had been given as prescribed. These concerns had not been identified by the service until we raised them with a member of staff. Incident forms for medication errors did not always evidence that all the relevant parties were informed. For example, there was no evidence that a GP had been informed when a person had refused five out of six of their tablets that were prescribed.

Two people were receiving their medicines covertly. This means that medicines were hidden in either a drink or food item to ensure the person received the medication. Once a decision to administer medicines covertly has been made, advice should be sought from a pharmacist about the suitability of each medicine for covert administration. The medicines policy of the provider did not reference the need to seek input from the pharmacist and we saw no evidence that advice had been sought from a pharmacist regarding the suitability of the medicines for covert administration for either person. These had been requested on the first day of the inspection and received by the second day of the inspection.

Practice was inconsistent in relation to the safe storage and application of creams. Several people had two of each medication opened in their rooms, which meant staff would find it difficult to know which cream was in current use. In some cases it appeared that both creams were in use. Some creams had not been dated and had 'Use as directed'. For example, a person had been prescribed a gel with 'as directed' but no other information to guide staff. It also had no date of opening. This was not good practice as it did not provide sufficient information for care staff to follow. Two creams were found inside the fridge, one of which has past the storage date. The nurse confirmed that these creams were no longer prescribed for the person. We were told there was no process in place for the cleaning or defrosting or checking of the medicines fridge.

Where instructions were given, these had not always been followed. For example, we saw that Ibuprofen gel should have been applied three times a day but had only been applied twice a day. There were two tubes of ibuprofen open, one had no date of opening yet was dispensed on 17/10/2016. The other tube had a date of opening specified as 3/10/2016 and it was dispensed on the 21/8/2016.

Creams and ointments had been stored in a plastic box as there was a lack of storage. The box was full and was in no identifiable order. Therefore it was difficult for staff to see at a glance what stock there was and the level of stock.

Staff who applied medicated creams had received no training on how to do this safely. We asked a member

of care staff how they applied ibuprofen gel and they reported they did not wear gloves to apply this, but washed their hands regularly. This meant the care staff could absorb some of the gel which could have health implications for themselves. By the second day of the inspection, cream competencies had been completed for all carers.

People's care plans contained risk assessments which included risks related to: moving and handling; nutrition; falls; mobility and pressure damage. Risk assessments were reviewed monthly. Where risks were identified care plans included guidance on how to manage the risks. However, we found that information in care plans was not always up to date. For example, one person's care record included a risk assessment relating to pressure damage. The care plan for 'skin care' stated, '[Person] has a wound on her right leg and is a stage two wound'. There was no guidance relating to how the wound was being managed. We spoke with a member of staff who told us the person no longer had a wound.

People's risks were not always managed in line with guidance. For example, we noted a white bowl containing toiletries on the floor in a person's doorway for 45 minutes. We saw the person's records stated they were at high risk of falling and stated 'Staff to ensure safe clutter free environment where possible'. We also noted that a bath was being run in a bathroom nearby. We noted no care staff were in the bathroom. After a couple of minutes a care staff member entered the bathroom and turned off the taps and left the bathroom leaving the door open. We saw that the person came out of their bedroom and entered the bathroom alone and turned on the taps. After a few minutes a staff member entered the bathroom and turned off the taps. We saw on this person's records that they had a high level of risk around bathing. This was due to the risk of falls and potential drowning and scalding. To minimise these risks it stated that the person was to remain supervised in the bathroom. Lack of supervision placed this person, and potentially others, at risk of drowning if they entered the bathroom unattended.

We also found that information relating to risks was not always consistent. For example, one person's dietary needs care plan identified the person enjoyed a 'varied pureed diet' and that if the person had problems swallowing they should be referred to the speech and language therapist (SALT). However, on the person's medicine care plan staff were advised to 'give one tablet at a time as she is at risk of choking'. We spoke to a member of staff who told us the person had not been referred to SALT. We could not be sure the risk of choking was being safely managed for this person as we could find no evidence this person had been referred to SALT.

Equipment in use in the home was not of an adequate standard to keep people safe. We inspected three bed rails with the home manager and these were all set at below the minimum height in accordance with bed rail guidance from the Medicines and Healthcare products Regulatory Agency (MHRA). This meant that people were at risk from falling out of bed.

Although the providers bed rail policy included the correct measurements for bed rails once in situ there was no process in place whereby staff could assess and document that the bed rails currently in use were compliant with the guidance. When used in conjunction with a pressure relieving mattress they were not meeting the Medicines and Healthcare products Regulatory Agency (MHRA) guidance. We were informed that a maintenance person checked the bed rails. However, an inspection of the documentation they kept showed that bed rails were not included within the checks completed. We discussed this issue with the Chief Operating Officer and the registered manager. We also spoke with the compliance manager who said they had been awaiting a report from a supplier who had audited the bed rail heights in July 2016 and this was chased up in October 2016. Due to this still being outstanding on the day of the inspection, the provider took steps to rectify the situation by ordering new beds with integral bed rails that they believed would be compliant. They also put in measures to ensure people were safe whilst awaiting delivery of the beds.

Not all people had sufficient information in their care plans to enable staff to safely choose the correct size slings to safely move people when using hoists. Neither the moving and handling risk assessment or care plans specified the sling size. For example, one person had two slings in their room and neither of these were marked with the person's name. We saw on the provider's continuous improvement plan (CIP) that an action to 'label sling with names' was stated as completed on the 19 October 2016. This was not the case.

None of the pressure relieving mattresses we reviewed were set at the correct setting in line with the person's weight. This meant that potentially the mattresses could increase the risk of pressure ulcers forming. For example, we saw one person's weight was below that of the minimum setting for the mattress that they were on, as the minimum setting was 40kgs and the person's weight was 35.6kg. We saw on the provider's continuous improvement plan (CIP) that 'all mattresses should be checked monthly'. We noted at least five mattresses we checked were not at the right setting.

A sharps bin was seen in use in the clinic room and had no date of assembly. A sharps bin is a container that is filled with used medical needles or other sharp medical instruments. If the sharps bin is seldom used, it should be replaced after a maximum of three months regardless of the filled capacity. Therefore the sharps container must be signed and dated on assembly in order to identify when three months have expired.

The local authority Quality Monitoring team had sent the CQC a report from September 2016. One of the actions stated a ground floor store room 7 should have locks fitted and be locked. The action had been signed as completed by the registered manager on the 25 October 2016. On the day of the inspection, we noted store room 7 was unlocked at 09.25 and able to be opened by any mobile person. We checked again at 11:47 and noted the door was still unlocked, had the lights on and contained wheelchairs, one with loose footplates, and behind a folding screen a lot of other mobility aids. This meant people could access this room and potentially be harmed. Equipment was not always safely stored. We saw a hoist and sling outside a room which was plugged into the socket. We also saw computer tablet chargers plugged into a socket in the corridor with cables on the floor.

People were not always protected by the prevention and control of infection. A care worker was observed carrying dirty bed linen against their clothes and was not wearing an apron. This meant that cross contamination could happen when care was been given to a person. We heard comments from relatives that bins were only emptied twice a week and they felt the need to clean them when they visited. One relative said "The lack of cleaner's means staff have to do the cleaning as well as caring. The cutlery and crockery is often dirty with dried food on it". Another relative expressed concerns about the cleanliness of the home. One relative commented, "Hygiene in the home is very poor. Tables are filthy and the bins are only emptied once a week". We were told that at a residents meeting on the 13th October the registered manager pointed out that they were three cleaners short and were currently interviewing for staff. The registered manager said that two agency cleaners had been employed but we heard about continuing concerns about the levels of cleaning after the inspection.

We saw the lock on one sluice room was broken. A member of staff told us the lock had broken during the previous weekend and was in the maintenance book to be repaired. We checked the maintenance book and there was no record of the broken lock being reported. A second sluice room door was open. We asked a member of staff who advised us that the sluice room door was, "Normally left open". There were three people who were independently mobile in that area of the home who may have been able to access the sluice.

These issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that the home was very large and many people were being cared for in bed. During the inspection we saw people went for long periods without staff visiting them. For example, one person was left with a cup of tea and a bowl of breakfast cereal. No-one checked they were eating and drinking for 30 minutes. Another person who was in bed was not checked by staff for 45 minutes. Staff passed this person's room on three occasions but did not check on the person.

Staff told us there were enough trained staff to properly care for people. One member of staff told us, "More often than not required staffing levels are not achieved. We can only provide basic care. Today there is no supper chef so we have to go and collect food from the kitchens ourselves and prepare the supper. That takes us off the floor". Another commented, "We only had four this morning. It means people have to wait longer. We can't meet (people's) needs and we don't have time to sit and talk with them" and another commented, "We should have nine in the morning and eight in the afternoon. Yesterday we only had eight in the morning and seven in the afternoon. It means we don't have time to spend with people. They do try and get it covered".

Before, during and after the inspection, relatives told us there were not enough staff to ensure people's needs were met. A relative told us they visited at midday and their relative was still in bed and had not been washed. They were told on enquiring that there were only two members of staff on that floor and that they were very busy. We had many comments from relatives such as, "They (care staff) work hard, but there are not enough of them. The place has gone downhill"; "I come in every day to ensure my (relative) gets the help they need"; "The thing that worries me most is the staffing levels. On occasions there has only been one carer to cover which is very unsafe" and "Sometimes they are short of staff. Staffing at weekends can be more of a problem".

We asked the Chief Operating Officer and the Registered Manager how they assessed staffing levels and they stated a dependency tool was used to assess safe staffing levels. Planned staffing levels were regularly, but not consistently maintained as evidenced by the staff rotas. 'Safe' or minimum staff levels were planned. Following a complaint earlier in the year, we had contacted the home and they had replied that the 'safe' ratio was only used when staff were sick and cover could not be found. They said if numbers fell below 'safe numbers' they were permitted to use agency if requested to the Chief Operations Officer. From the rota's we were shown we saw on most days that only safe levels were planned. Following the first day of the inspection, we were told that the use of agency staff had been permitted to improve staffing levels.

We found that failing to deploy sufficient numbers of staff to make sure people's care and treatment had been met was impacting in areas of the service we inspected. For example, staff not being able to be effective in ensuring people's nutrition and hydration needs were met, not having the time to spend with people and provide care and dignity as well as records not being updated to clearly reflect people's needs.

These issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that two people had skin tears. Neither person had care plans completed for the care of these injuries and neither injury had been reported as incidents. One of the skin tears had not been inspected or redressed for more than two weeks. A dressing was changed by night staff on the morning of our inspection, but this change of dressing was not recorded until late morning and by a different member of staff. This meant that professional guidance about recording care delivered had not been adhered to. For example, keeping clear and accurate records and completing all records at the time or as soon as possible after an event.

These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about their responsibilities to identify and report abuse. One staff member said, "I have done on line training about safeguarding so I know what it is. I would report immediately to [manager]. She then raises it with safeguarding (Local authority safeguarding team)". A second member of staff commented, "I would report to [registered manager] and if nothing was done I'd go higher. If necessary I could go to social services or the police". The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so.

A check of some of the contents of the controlled drugs (CD) cupboard found that medicines records were completed accurately and stock levels checked at least daily which demonstrated good practice. A CD destruction kit was available and kept in the CD cupboard which is good practice. The registered nurse was able to evidence that the GPs had undertaken some annual medication reviews.

Inadequate

Is the service effective?

Our findings

When we inspected in November 2015, the provider had not ensured people were always supported to have their nutritional needs met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we saw little improvement to ensure people were receiving appropriate support to receive adequate nutrition and fluids. People's dietary needs had been identified, but records were not always consistent and staff were not always clear about people's needs. For example, one person's room records included a recommendation from a speech and language therapist (SALT) relating to the consistency of food and drink the person required. The person's relative told us the person no longer took any food and fluids orally as they received their nutrition through a percutaneous endoscopic gastrostomy (PEG). This was confirmed by a member of staff. However, we spoke to the clinical lead who told us the person was still being encouraged to take a small amount of food and fluid orally. There was a letter from SALT on 30 November 2015 confirming the person could still be encouraged to take oral nutrition. The person's relative was not aware of this and care staff were not supporting the person to take any food or fluid orally.

Where people had been referred to SALT we saw that guidance was not always followed. For example, a person had lost a lot of weight during a four month period. They had been referred to and visited by SALT following concerns about their weight loss. SALT had identified the person was being offered food at mealtimes and often refused. The person was not being offered food in between meal times which had resulted in the person going long periods without food. SALT recommended the person be offered food and drink more regularly and to offer alternatives if the person did not like the pureed food available. We saw the day following the SALT visit the person had been offered a variety of food and drink on seven occasions throughout the day and their consumption had improved. However, this was not maintained and records did not show this person was being offered a variety of food outside of mealtimes and amounts of food being consumed at mealtimes were very small.

We observed people during the lunchtime period in all dining areas of the home. In one of the dining rooms in the dementia unit, we noted that a person received no support with eating their meal. We saw this person trying to pour the juice in a beaker onto their dinner. A care worker approached and took off the lid of the beaker and handed it back to the person. The person then put their fork into the beaker and then put their fork into their mouth. It was some time before they eventually tried to get some food off their plate into their mouth. The person struggled to manage and food was dropping off the plate onto the table and into their lap. A care worker came into the dining room and noticed that the person was struggling. They made a new drink for the person and attempted to help them. However, this care worker was delivering food to other people so only spent a couple of minutes before leaving to take more meals out. We saw two other care staff on duty in the dining room make no attempt to assist the person. One made a comment about the person needing a plate guard to stop the food falling off but took no action. After half an hour another member of staff entered the room and immediately noticed the person had not eaten and needed help. They assisted the person to eat and encouraged them to have a pudding. We saw later in this person's records that they had a poor appetite and if they were having a bad day may need help to eat. We also noted this person had

lost weight.

We saw another person's care plans state that their food and fluid intake needed monitoring. The last monitoring was in September 2016 and records showed an inadequate fluid and food intake. A nurse told us the person had fortified milk but this was not stated in the care plan. During the inspection food and drink were not observed being offered or encouraged outside of mealtimes or set drinks rounds.

We saw in the other dementia unit dining room that people were waiting a long time for their meals. One person that was able to eat their lunch independently was observed to have eaten all their lunch and was then observed eating all of the gravy on the plate with their spoon. The person then ate all their pudding and did similarly with the custard, ensuring every drop was eaten. We waited to see if the person would be offered the option of having more lunch but this did not happen. The inspector suggested to the care staff that the person might like some more lunch and when this was offered, the person ate another large dish of the main course followed by another helping of the dessert. It was evident that the person, who was slight in weight, was still hungry.
At lunchtime, people that did not require a pureed or softened diet were waiting 40 minutes whilst people who did were served. This meant that some people fell asleep at the lunch table whilst waiting and one person became verbally very loud, shouting out and swearing at times. Care staff did not intervene or attempt to engage the person.

We asked people their opinions of the food and had varying replies. On person commented that, "I would say that the portions are rather small here" and "I don't like the food". This person left most of their lunch. Relatives commented, "The food seems to be overcomplicated. Does it need to be as complicated as they make it or could we just have simple food well cooked?", "Mealtimes are particularly pressured and the times of meals vary a lot, supper can be as early as 4.45 pm or as late as after 6 pm" and "I feel I have to come in every day to ensure my (relative) gets the assistance to eat as I am not confident this would happen".

These issues are a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all staff had a clear understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA). 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. Staff had undergone training. One staff member said, "We have to assess their (people's) needs, for example if they're in pain. They are not always able to consent". Other staff were not clear about the MCA and how it should be applied. Comments included, "I have done Mental Capacity Act training on line, but it's not the way I like to learn" and "I did do training on MCA but it was e-learning. I prefer face to face training as I can ask questions". This meant staff were not equipped to respond appropriately to people who may struggle to make decisions.

People's care plans contained information relating to people's capacity to make decisions about certain aspects of their care. For example, one person had been assessed as lacking capacity to make complex decisions relating to their care needs but could make simple decisions. The capacity assessment included information relating to who should be involved in any best interest decisions that may be necessary. However, we found there were not always capacity assessments where people were receiving support they were unable to consent to. For example, one person was receiving their medicines covertly. There was no

evidence of a capacity assessment being completed in relation to this decision. This person's care record also stated that there was a family member with legal authority to make decisions on the person's behalf. The provider did not have a copy of the documents giving authorisation.

Where bed rails were in use, a capacity assessment and best interest decision making process in accordance with the MCA had not been followed. We also saw that a person had a sensor mat in place. We saw no capacity assessment and the best interest decision making process had not been followed. The use of the sensor mat was not documented in a care plan. The person's care plan specified that they should have half hourly checks at night; however we found no record that these checks had taken place.

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 saw that DoLS applications had been made for some people. Copies of documents were kept on the person's file and where the deprivation had been authorised this was recorded. However, there was no record of the deprivation being reviewed to ensure any deprivations in place were the least restrictive option.

These issues are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the other two dining rooms, there was a calm and cheerful atmosphere during lunch. People who required support to eat and drink were supported in a respectful manner and at a pace that suited them. For example, one person was sight impaired. The member of staff took the person's meal to them and explained where their meal was and what was on their plate. The member of staff made sure the person had their knife and fork and was managing to eat before leaving them. Staff were quick to respond to people's requests for support. People chose what they wanted to eat earlier in the day and staff ensured people received their chosen meal. If people preferred to stay in their room this was respected.

As a result of many complaints about the food, the service had introduced a weekly meal planner and people requested to have them in their rooms. People could then choose from this each day with the assistance of family members or staff. However, it was noted that on three occasions the menu had not been adhered to as described.

Staff had access to development opportunities and staff we spoke with had completed national qualifications in social and health care at level two and three. Staff had access to training to help them meet people's specific needs. For example, staff spoke positively about training they had attended to understand how to support people with learning disabilities. Staff told us the training had helped them communicate with people and understand what some behaviour may indicate. A member of staff commented, "I have supervision with the clinical lead every three to six months. She will go through anything I have a concern with" and another said "I have done my level two and three (diploma in social and health care). A relative said, "Training is mostly okay, but some staff lack experience and for bank and agency staff it takes a while to get to know the [residents] which is what is really needed".

Care records showed people were referred to health professionals when needed. Records showed people had accessed their GP, care home support service (CHSS), podiatrist and optician.

Requires Improvement

Is the service caring?

Our findings

People felt staff were caring. We spoke with one person who said they were happy and commented, "It's just like being at home". They went on to say they had been a bit cold the night before and "I asked for a hot drink and it was brought to me". They also said they liked the activities and "Went to everything" and said there was "Something on each day". They finished by saying "This is my home; there's nothing I would change". Another relative told us, their relative had commented, "So lucky I'm going back to my lovely home".

Relatives were positive about the care staff, commenting "We see the carers always treating the residents very well, but they are so busy there is never any time for a real conversation" and "The staff are wonderful and always so cheerful" and "Residents are treated very well by the care staff and other relatives will look out for resident's including my (relative) and call staff if they are needed, but I wonder if this is really the relative's responsibility?" and "The carers do their best to keep the residents happy and contented, but it can be difficult when some of them are sick or on holiday as it would appear absences are not always covered".

One person that had been admitted the previous week from home described care staff as caring and kind. The person continued without prompting to say that she missed someone she was able to talk to. The person referred to themselves as being 'No chatterbox, but I might as well have stayed in my room'. This person had full capacity yet was placed in the area of the home that cared for individuals living with a dementia. When the person was asked if they had been invited to participate in any activities, they said no. The person said that they particularly liked Bingo. The activity co coordinator said that she would respond to this wish.

We saw many kind and caring interactions. For example, one member of staff entered a person's room. The member of staff cheerfully greeted the person and engaged them in conversation about how the person was feeling and whether they had slept well. They chatted with the person about what they were reading in the paper. On leaving the person's room the member of staff asked if the person would like their door closed.

Staff were reassuring when people became anxious and took time to calm them and explain what was happening. For example, two members of staff went to a person to support them with personal care. The person called out in an anxious manner. We heard staff reassuring the person and explaining why the staff were there and how they were going to support the person. Another person became anxious in a communal area of the home. A member of staff knelt down by the person, made eye contact and held the person's hand. They spoke out them about Christmas and started singing a Christmas song. The person was soon smiling and joining in the singing. Care staff were observed knocking and waiting prior to entering a person's rooms which is good practice.

Staff told us how they ensured people's privacy and dignity was respected. One commented, "I make sure I close people's door and close curtains when giving personal care. I knock on their door and will show them clothes to let them choose". Another staff member said, "I make sure I involve people. It's about

encouraging choices and prompting them to choose".

However, we observed some people's dignity was not always promoted. We observed several people sitting on incontinence pads in their chairs which highlights that a person is incontinent through their clothing. This was a concern as we had comments from relatives about incontinence pads not being changed for long periods of time leading to leaking. A relative said "The caring is kind and respectful and very friendly but the carers are run off their feet. [Relative] is a double up and so when you ring for help someone comes to answer only to have to go away and find someone else to assist, and often you can wait up to 30 minutes and this will happen two or three times a week. This effects [relative's] dignity and independence and gives a feeling of helplessness. The activities take carers away as does sickness and holiday and when two or three people want personal care at the same time it's not possible".

Several care staff on duty on the day of the inspection did not have name badges on, which meant that people would not know their name. Staff were not heard introducing themselves by name to people. For example, a carer walked into a person's room and said "Hello, we've not met". It turned out the carer had been on holiday when the person had arrived but there seemed no introduction before personal care commenced.

The home had tried to personalise people's rooms and make them more attractive and homely. People had one page summary sheets of needs and what is important to them hung on some bedroom walls to help carers have an overview of the person's needs at a glance, this is good practice in dementia care. However, quite a few people's rooms did not have their name on their door. Some people had memory boxes on the wall outside their rooms but seven of these were empty and one contained information relating to a person who had moved to another room. Ten rooms did not have any memory boxes outside them. The purpose of the memory boxes outside the rooms is to help people identify their bedrooms but these had not been completed for everyone.

Confidentiality was not always respected. We observed a serviette in a lounge with a list of people's names to be washed and dressed. There were 11 people listed by name with ticks against those whom the tasks had been completed. It was disrespectful to have this information recorded on a serviette and left lying around in a public area.

Requires Improvement

Is the service responsive?

Our findings

Up to date and accurate records of people's care were not always maintained. For example, a person had been prescribed a thickening agent for fluids. There was no record of administration. We were told that the person was no longer using the thickening agent but there was no record as to who made the decision to stop this and the date this happened. We saw the care plan for this person dated 22/10/2016 that specified that fluids should be thickened to a single cream consistency. The care plan had not been updated or reviewed since the 22/10/2016. The review date specified was the 22/11/2016, but had not taken place on the day of the inspection.

We saw recently published National Institute for Health and Care Excellence (NICE) guidance regarding oral health in care homes on display in the nurses' office. This guidance advises reviewing and updating people's mouth care needs in personal care plans to ensure care staff know how to recognise and respond to changes in a person's mouth care needs. However, one person had developed a mouth ulcer which was recorded on daily notes. However, there was no recording on a care plan about measures to manage this. This meant staff had not been kept up to date with changes to a person's needs.

The service did not always respond to people's changing needs. One person's room had a falls prevention checklist dated April 2013. The assessment identified the person was at high risk of falls. The risk assessment stated, "Check [person's] zimmer frame is in good working order and check [person] has suitable footwear. Be aware of [person's] whereabouts". We saw this person sitting in the communal area of the home. We asked a member of the care staff about this person's mobility. They told us the person was no longer mobile and required two members of staff and a hoist for all transfers.

People's care plans were stored on electronic care records and staff recorded the support people received via electronic devices available in the communal areas of the home. However, it was not always clear where food and fluid intake and repositioning were recorded. Staff told us, "The [electronic device] is unpredictable so we are still using paper records for fluids and repositioning. I think some staff do it on [electronic devices]"; "The [electronic devices] don't work all the time. We fill in forms in rooms and then when they're full we give them to the nurse who puts them on the system" and "Connection is not good so we still have cream charts and food and fluids in room but you can do them on the [electronic device]. We have repositioning charts on the [electronic device]". Recording information was done inconsistently. For example, we saw information recording food and fluids from breakfast for a person written on a serviette lying on the dining room table. It did not state who this was for. This meant the system for monitoring people's food and fluid intake and repositioning was not consistent.

These issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the complaints the service had received to evaluate how they had listened to and learnt from people's experiences. We saw that most complaints had been recorded and the date a response was given and when the complaint was resolved. However, we spoke with relatives who said that despite assurances,

complaints were not resolved. They said there had been a recent meeting to discuss the food but things had still not improved. They stated food had been a long standing concern with the standard of the food been constantly questioned at relatives meetings. They said promises had been made for improvements but none delivered. They said the production of a menu so people could choose had been disappointing. They stated the choice was poor, options limited and the nutritional balance 'appalling'. Choices were frequently not met and alternatives were 'foisted' upon people. The temperature of the food was also questioned. There was also a complaint about the cleaning standards. They understood the provider was trying to recruit cleaners but this was having an impact with rooms being poorly cleaned.

We also saw a complaint about a person being showered late at night. We saw the registered manager had emailed the night care staff to inform them it was not acceptable. However, during the inspection we were informed that this had happened again that week. When this was raised, the registered manager took immediate action to look into these concerns. We also saw a complaint had been made about concerns over a relative's weight loss. The registered manager had emailed staff to say they needed to ensure the person was encouraged with food. We saw no evidence on the person's nutrition recording that they were being encouraged to eat more.
We saw complaints during the month of November 2016 relating to staffing levels, concerns about a relative appearing dehydrated, menu's not being followed and levels of cleanliness. These had been responded to but during the inspection these were all areas of concern that had not been addressed.

The registered manager had received a high level of complaints in relation to staffing levels and quality and quantity of food throughout the year since the last inspection. However, there was little evidence of improvements being addressed in relation to these trends so that they may be improved in an acceptable timeframe.

We also heard from three relatives who all stated that when they had voiced their concerns, the Chief Operating Officer had stated that if they were unhappy they could always move their loved ones to another home. We had a comment from a relative who said, "Speaking with other relatives they have said if complaints are made, they are just told may be you should take them elsewhere if you don't like it". This meant that families could feel compromised about expressing their concerns in case of recriminations. Another relative said, "I don't want to move my [relative], I just want things to get better".

These issues are a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records contained some information about people's likes dislikes and life histories. For example, one person's care plan detailed the importance of supporting the person to maintain contact with a family member. The persons' care plan also detailed the person enjoyed puzzles and music. We also saw information about a person's past employment and about their interests such as travelling. It also noted the person was sociable and discussed their hobbies.

We were told there were three activities coordinators and spoke with one co-ordinator who showed us records of people involved in activities, which also detailed if people declined to take part, were sick, or had one to one meetings in their rooms. A newsletter was produced monthly and reported about events that had taken place such as events to celebrate Guy Fawkes and Remembrance Sunday. This had been marked by a singer visiting and was reported as well received. There had also been an after dinner cheese afternoon arranged and due to the success another of these had been planned. There was a monthly timetable produced listing what activities had been organised such as church choir visiting and a pantomime.

Inadequate

Is the service well-led?

Our findings

The service was led by a registered manager. They were supported by a deputy manager and an area management team. After the last inspection, we were informed that the management team had a clear plan for further changes and improvements to improve the quality of service people received. An action plan was submitted to address the two breaches. We found at this inspection that the required improvements had not been made as the issues found on the last inspection, were still present and further concerns were identified in respect of staffing levels which impacted upon most areas of the effective and safe delivery of care.

Staff told us that morale was currently low. One said, "People (staff) are leaving. Staff don't find [manager] very approachable". Another said, "Morale is so low. Staff are leaving and new staff don't stay" and another said, "We have a heavy workload and we are not feeling valued. We are short of staff and relatives are not happy". A staff survey had confirmed that staff felt very negative about the registered manager. We saw a record of a meeting following this survey where the registered manager had invited staff to have a frank and honest discussion about improving the relationship. Following this a workshop had been organised to talk about values. Staff said they knew that the outcome of the workshops had been fed back to the registered manager but they were not aware of what was happening as a result.

Some relatives and staff said the registered manager was not 'present' much in the home, spending a lot of time in the office. A staff commented, "She doesn't come on the floor and people don't know who she is". A relative told us, "Previous managers used to pop in and have a chat and speak with my relative, this doesn't happen now". However, some staff told us the registered manager was approachable and they felt supported. Comments included, "[Registered manager] is really supportive and other nurses have taken me through everything", "[Registered manager] often comes and helps, we can use agency if we need to" and "[Registered manager] would try and help you if you had a problem. She has an open door policy and you can talk to her when you want".

We had feedback from a professional who stated they felt unwelcome when visiting the home and it was often difficult to find staff to discuss things with. The professional described staff as being "Abrupt at times" but that this seemed to be related to them being under pressure. The professional felt that the reception at the home was significant to make them feel they needed to raise their concerns. They had also reported these to the Chief Operating Officer but said no improvement had been noticed. We also spoke with the local authority contracts team who had undertaken a review in September 2016. They shared an action plan which the registered manager had completed stating that all actions had been completed. For example, a lock on the store room door. We found this had not been done.

Incidents and accidents were recorded on electronic records. However, we did not see all recording from daily notes had been noted on these records. For example, a person who had an injury when being transferred did not have full details about what had happened. Another person told us they had their arm trapped in the bed rail and this also was not noted in the accident and incident records. We saw on the Continuous Improvement Plan that falls were analysed monthly but that other incidents needed to be

recorded and monitored. It stated that accident and incident analysis forms were now implemented in the service from October 2016. However, it was not clear how incidents such as injuries sustained during care were analysed and acted upon to reduce these happening.

Relatives told us that there were meetings held at which they could discuss improvements that they wanted. However, relatives expressed concern that changes resulting from these meetings were minimal. We saw records of the minutes following each meeting. The issues had been brought to our attention, by relatives during the inspection. This showed that any action taken to address people's concerns had been ineffective. We saw that an external consultant had been arranged to discuss the dining experience. This was due the week of the inspection

During the course of our inspection we looked at the documentation within the care records, including that related to risk assessments, food and fluid intake and skin integrity. We noted that these records had not always been completed correctly and had not been updated where changes had occurred.

Staff felt supported by their managers. However, we saw on the supervision and appraisal matrix that 11 staff had no supervision recorded at all and the remainder of staff had last had supervision in 2015. Fourteen staff had supervision recorded either in October or November 2016 but the remainder had no planned supervision on the schedule. We saw no records of annual reviews in 2016.

Concerns had been raised with the registered manager in mid-November about night care staff. The registered manager had sent an email to night staff but had not conducted any visits at night or spot checks on night staff. The registered manager told us this was planned, but these concerns had not been responded to promptly. During the inspection, we were informed by a whistle-blower that staff were getting people out of bed and dressed at 4.30am. They also said a person had been left alone in a lounge all night. When it was suggested that they should be supported to go to bed a comment was made that "[Person] gets out of bed and urinates on the floor so we don't put [person] to bed". This person was left alone in the lounge awake until 5 am unsupervised. We saw from the person's records that staff had recorded '[Name] refused to go to bed. This person had information in their room stating [Relative] has no concept of getting undressed and going to bed, so will need to be put to bed'. This concern was reported to the registered manager and the safeguarding team who investigated these claims. The lack of effective systems to promptly respond to concerns meant that people had been exposed to a continued risk of poor care.

Quality Assurance audits had been carried out and these were evidenced on the Continuous Improvement Plan. However, the plan stated actions were complete but we found at the inspection that the issues identified were still ongoing. For example, we were given the latest plan dated 25 September 2016 which had been updated on 2 December 2016. We saw areas that had been audited such as a weekly medicines audit completed on 18 October 2016. Issues had been identified where staff had not signed MARs, handwritten MARs were not completed correctly, boxed medication with no opening date, medications running out of stock, PRN protocols not up to date and fridge temperatures not signed. These issues were marked as completed in November 2016. However, we found these concerns were ongoing at the time of the inspection. We also saw that the cream charts were to be included in the weekly medicines audit and to chase staff up for missing signatures. We saw that there had not been an external audit of medication over the past two years. The provider had recently requested this by the new pharmacist. A meal time audit had been carried out and stated improvement had been noted. However, our observations were that meal times were still a cause for concern, particularly in the dementia unit. The registered manager said that a consultant had been arranged to give the home feedback about what improvements were needed. Despite these issues being identified during audits, there had been a failure to take effective action to ensure that medicines were managed safely and people received the nutrition they required. We also saw that despite

numerous meetings about the relative's concerns timely and effective action to address these concerns had not happened.

These issues were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not done everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked the mental capacity to make an informed decision, the provider and registered manager had not acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.