Care Quality Commission

Bupa Care Homes (BNH) Limited

St George's Nursing Home

Inspection report

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Date of inspection visit: 14 October 2015
Date of publication: 30/12/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection was carried out on 14 October 2015. St Georges Nursing Home provides nursing care for people who are living with dementia and is registered to accommodate up to 63 people. On the day of our inspection 57 people lived at the service. The accommodation is arranged over two units over one floor. One of the units is for people with more complex needs and who may have behaviour that may challenge.

There was a registered manager in place who was present on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We were also assisted by the regional manager.

There were not always enough staff deployed in the service to consistently meet people's needs. People sometimes waited long periods of time before they received support from staff. There were times where there were less than the required staff needed to care for

Summary of findings

people safely. There were no assurances that before staff started work appropriate recruitment checks had been undertaken. There were gaps in staff records and appropriate references or checks had not always been obtained.

Risk assessments did not always detail the support people needed. There was a lack of information for staff on some of the identified risks. We found that the environment was not always safe. Some furniture was arranged in way that was difficult for people to manoeuvre. Other risks had been assessed and guidance provided to staff on how to reduce them which included the risk of pressure sores and choking. There had been accidents and incidents recorded but there was a lack of analysis of what the registered manager had done to reduce the risk of falls and incidents in the service.

People's rights were not always met under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect them from harm. Assessments had not always been completed specific to the decision that needed to be made around people's capacity. DoLS applications had been submitted to the local authority. Other staff did have an understanding of MCAs and DoLS and were able to explain to us the reasons why assessments were undertaken.

People were not always receiving care from staff who had received appropriate training. There was a risk that people were receiving care from staff as they were not always kept up to date with the mandatory training including dementia and health and safety training. Nursing staff were not up to date with their clinical training.

Staff were not always supported in their work and said that they did not have regular supervision with their manager. They said "I don't know whether I'm doing well or not." There were over 60 staff who had not had a supervision with their manager this year. There was no opportunity for staff and their manager to discuss their performance or any ongoing training needs.

The environment did not always meet the needs of the people that were living there, particularly those who were living with dementia. There were very few destination points or signage to help orientate people around the service and assist with their independence.

Staff at the service were not always caring. There were times during the inspection where staff were not as supportive as they could be. People were ignored for periods of time throughout the day and on occasions staff chatted amongst each other and did not interact with people especially during the meal time. We did see times when staff were caring and considerate to people. People were complimentary about the staff. One person said "The carers are very good, they are kind"

People felt safe and staff had good knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. There were clear policies in place to guide staff should they have any concerns. Medicines were stored appropriately and audits of all medicines took place. Medicines Administrations Records (MARs) charts for people were signed for appropriately and all medicine was administered, stored and disposed of safely by staff who were trained to do so.

People's preferences were not consistently being met. One relative told us that they were involved in their family members care and were contacted about any changes that had occurred. Staff at the service had the details of an advocacy service where people needed the support. The service was not always responsive to people's needs. There was information missing in people's care plans around support they needed. One person had been in hospital after having a significant injury but their care plan which had been updated didn't reflect their current needs. Communication was not always shared with staff about people which put people at risk. The registered manager confirmed this and said that they were working on ways to improve the communication and sharing of information with staff.

There were not enough meaningful activities on offer specific to the needs of people living at the service. There were long periods of time where people had no meaningful engagement with staff. One person said to us "Sometimes it gets a bit boring but I do enjoy the exercises" whilst we heard another person say "I think I will go to bed, this is boring."

Summary of findings

Although people, relatives and staff felt that the registered manager was likeable, many of them reported that management was ineffective. There was not always consistent and obvious leadership in the service and staff said they didn't always feel supported or valued. Not all staff received annual appraisals to discuss their performance or training and development needs. However some staff told us that the manager's door was always open and felt that they could go to see them whenever they wanted. One told us "He (the manager) is always very visible and checks everyone is ok, his door is always open."

There were not effective systems in place to assess and monitor the quality of the service. Audits and surveys had been undertaken with people, relatives and staff but had not always been used to improve the quality of care for people. Records were not always completed accurately and were not always complete. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had not informed the CQC of significant events in a timely way.

There were times where staff responded appropriately to people's care. One relative told us "I feel the home is outstanding and the nurses are excellent." They told us that the staff had responded quickly to their family members' ill health and felt that the family member would not be alive today without their intervention.

In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and make them safe. Where people needed to have their food and fluid recorded this was being done appropriately by staff. Intake and output of food and fluid was recorded on forms that were kept in people's rooms.

Nutritional assessments were carried out when people moved into the home which identified if people had specialist dietary needs.

People had access to a range of health care professionals, such as the GP, dietician, Parkinson's nurse and chiropodist. One health care professional told us that staff at the service regularly had contact with the local mental health team.

There was a complaints procedure in place for people to access. The registered manager told us that since taking up post they had not received a single complaint.

The overall rating for this report is 'Inadequate'. This means that it has been placed into 'Special measures by CQC. The purpose of special measures is to;

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement power in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such as there remains a rating of inadequate for any key questions overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the providers registration.

During the inspection we found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not always safe.

There were not always enough staff deployed at the service to meet people's needs. Safe recruitment practice was not always followed, there was missing information in relation to the recruitment of some staff.

People were not always safe because risks of harm from behaviour and the environment had not been suitable managed. However staff were aware of other risks to people and how to manage them.

People received their medicines on time and as prescribed. Medicines were stored appropriately.

People told us they felt safe and staff understood what abuse was and knew how to report it appropriately if they needed to.

Is the service effective?

Requires improvement 

The service was not always effective.

People's human rights were at risk because the provider had not followed the requirements of the Mental Capacity Act 2005 and people's capacity assessments were not always completed appropriately.

Staff did not always have the most up to date training to be able to meet people's needs. Staff said they felt unsupported in for the work that they undertook.

Adaptations to the environment were not always effective at meeting the needs of people living with dementia.

People were provided with nutritious food and drink. People said the food was good. Peoples' weight and nutrition were monitored and all of the people had access to healthcare services to maintain good health.

Is the service caring?

Inadequate 

The service was not always caring.

People were not always treated with kindness and compassion and their dignity was not always respected. We did see occasions where staff were kind and considerate to people.

Where people had expressed preferences around their care, these were not always supported by staff.

Is the service responsive?

Inadequate 

The service was not always responsive.

Summary of findings

There was not always the most up to date information available to staff about people's care needs. Changes in peoples support needs were not always met.

There were not enough activities that suited everybody's individual needs.

People knew how to make a complaint and who to complain to.

Is the service well-led?

Inadequate

The service was not well-led.

There were not appropriate systems in place to monitor the safety and quality of the service. Records were not always complete and accurate.

Where people's views were gained this was not used to improve the quality of the service.

Staff did not always feel supported. However staff did say that the manager was approachable. The culture of the service was not very supportive to staff.

Notifications of significant events in the service had not been made appropriately to CQC.

St George's Nursing Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on the 14 October 2015. The inspection team consisted of three inspectors and a specialist nursing advisor. The nurse specialised in care for people living with dementia.

Prior to the inspection we reviewed all the information we had about the service. This included information sent to us by the provider about the staff and the people who used the service. As we undertook this inspection due to concerns we had we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked through notifications that had been sent to us by the registered manager. A notification is information about important events which the provider is required to tell us about by law.

During our inspection we spoke with the registered manager, the regional manager, 11 people that used the service, four visitors, 13 members of staff and two health and social care professionals. We looked at a seven care plans, recruitment files for staff, medicine administration records, supervision records for staff, and mental capacity assessments for people who used the service. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service. We observed care being provided throughout the day including and during a meal time.

The last inspection of this home was on the 17 September 2014 where we found our standards were being met and no concerns were identified.

Requires improvement

Is the service safe?

Our findings

People's needs were not always met because there were not enough staff deployed at the service. There were times during the inspection where people were not responded to in a timely way due to staff not being readily available to meet their needs. One person told us they needed to use the toilet and were feeling uncomfortable as a result. They had asked a member of staff to help them but due to them not being independently mobile they needed the support of two members of staff before this could be completed safely. We returned to the person approximately an hour later and were told by staff that they were still waiting for assistance from another member of staff. We intervened and asked a senior member of staff if they could assist the person as the person was in considerable discomfort by this time. We saw that there were periods of time throughout the day where staff were not always visible because they were busy providing support to people. This left some people unsupported in some areas of the service.

People told us that more staff were needed to meet their needs. One person said, "We could do with a few more staff here, sometimes it takes a while for staff to answer the bell." Call bell records for the three days before the inspection showed more than 10 occasions where people had to wait for 20 to 30 minutes for the bell to be answered by staff. There were people still in their beds at 11.30am and their curtains had not been opened. Staff told us that other people had taken priority with their care and that these people were still waiting to get up . The registered manager told us that there are times where the call bell is moved by people using the service and that this could explain some of the delays in the call bell being responded to. They were unable to tell us when this may have happened.

The registered manager told us that 13 care staff were required during the day to safely meet people's needs. They said they usually worked with 12 care staff, but at times staff levels had fallen below this. Staffing rotas confirmed that over the previous month there were more than 14 occasions were staffing levels did not meet the minimum safe requirements as set by the registered manager. The registered manager told us that at times these gaps were filled with other staff, for example the activities coordinator.

Staff confirmed they felt there were not enough staff to support people. One told us "We are short staffed; there are always less than we should have." Another said "There are not enough staff." They told us that this impacted on the care that people received for example in relation to not being able to spend as much time with people as they would have liked. One person had to wait for 20 minutes before they were supported to cut their food by a member of staff.

There were not always sufficient numbers of staff deployed around the service to ensure that people's care and treatment needs were being met. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's safety was put at risk because appropriate checks were not always carried out on staff to ensure they were suitable to support the people that lived at the service. Gaps in staff recruitment records meant that the registered manager could not assure themselves that only suitable staff had been employed to work at the service. Issues such as staff starting work without having criminal conviction checks completed, or the risk to people being assessed when employing ex-offenders, and gaps in employment history, all put people at risk of coming into contact with inappropriate staff.

Safe recruitment processes were not always followed. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's safety could not be assured because not all identified risks of harm were appropriately managed. One person had a particular behaviour that also put other people in the service at risk. There was no clear guidance to staff on how to reduce the behaviour or ways to occupy the person or strategies to help minimise the risks. We saw the person had been supported by a female member of staff on at least nine occasions according to their care plan where it stated that they needed to be supported by a male member of staff. A risk had been identified for another person which stated that they needed 'A structured day to support their anxieties' however we saw no evidence of this being done on the day. The person had been left unsupported. After looking at the persons care plan we found that other people in the service had been put at risk

Requires improvement

Is the service safe?

of harm as a result of the person being left unattended. The registered manager agreed that the service were not able to meet this person's needs but there was no evidence that alternative arrangements had been made.

We found that the environment was not always safe as furniture was arranged in way that was difficult for people to manoeuvre without difficulty. We saw one person trying to turn around with their walking frame but had difficulty doing this because of the way the chairs were placed. Accidents and incidents were recorded which showed that over a period of one month there had been a high number of falls. There was no analysis completed by the registered manager to see what action could be taken to reduce the risk of falls and incidents. The registered manager agreed that there were too many chairs in the lounges and said that they had been looking to address this.

People were not always protected from the risk of harm. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks had been assessed and managed appropriately to keep people safe. This included the management of manual handling where people had mobility problems, nutrition, skin care and personal care. Risk assessments were also in place for identified risks such as malnutrition and choking with clear guidelines on the action that should be followed by staff. One person was at risk choking, they were provided with thickened fluids to minimise the risk of this occurring and were also given a soft food diet. There was clear guidance to staff on these risks and what they needed to do to support this person safely.

People would be safe in the event of an emergency because appropriate plans were in place. In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and made them safe. There were personal evacuation plans for each person that were updated regularly and a copy was kept in the reception area so that it was easily accessible.

People's medicines were administered and stored safely. One person said that they would "Always" get their medicine on time (which was very important for their health condition). We looked at the medicines management and administration at the service and observed a nurse undertaking the medicines administration round. We saw that people who needed their medicine first were prioritised so that they received it in a timely way. Medicines were stored appropriately and audits of all medicines took place to ensure that there were sufficient quantities. Medicines were stored securely in a medicine cupboard which was locked and only accessed by staff who had appropriate training. We looked at the Medicines Administrations Records (MARs) charts for people and found that administered medicine had been signed for appropriately. All medicines were disposed of safely. There were photos of people in the front of each chart to identity who the medicine had been prescribed to.

People told us they felt safe with the staff. Staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. Staff said that they would refer their concerns to the registered manager and if necessary to someone more senior. There was a Safeguarding Adults policy and staff had received training regarding this. There were flowcharts in the offices to guide staff and people about what they needed to do if they suspected abuse.

Requires improvement

Is the service effective?

Our findings

People's human rights could be affected because the requirements of the MCA and DoLS were not always followed. Staff didn't always understand their responsibilities under the Mental Capacity Act 2005 (MCA), or the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

People were at risk of having decisions made for them without their consent, as appropriate assessments of their mental capacity were not completed. There was not enough evidence of mental capacity assessments specific to particular decisions that needed to be made. Where a best interest decision had been recorded there was not always an appropriate assessment in relation to this decision. There was not always enough detail about why it was in someone's best interest to restrict them of their liberty where necessary.

We were told by a member of staff that one person was provided with one to one support when they were not in their room. There was no evidence of a capacity assessment about this or a best interest decision about the person being subject to constant supervision from staff. We saw that one person's MCA assessment was around their capacity to made decisions for themselves. One member of staff told us that as they didn't get involved in the capacity assessments and that they did not understand it fully.

The requirements of the MCA were not being followed and DoLS were not applied for where necessary and in someone's best interest. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other staff did have an understanding of MCAs and DoLS and were able to explain to us the reasons why assessments were undertaken. Staff gave examples of where they would ask people for consent. For example one member of staff told us that they would also ask the person if they agreed if they could provide clinical care before they did it.

People did not always receive care from staff who had the training and experience to meet their needs. All of the people at the service were living with dementia. Some of the staff we spoke with were not always able to tell us about the specific needs of people with dementia. One member of staff said "I don't know if any training can fully help you understand people with dementia, their (people's) needs are really complex." Another member of staff told us that they although they had received training around people living with dementia they didn't feel it was detailed enough. They told us that they would like additional training to understand what's important to people and the environment that they were living in.

The registered manager informed us after the inspection that all staff underwent some training during their induction but that this was not detailed training around the needs of people living with dementia.

There was a risk that people received care from staff who had not had the most up to date guidance and training. Staff were not always kept up to date with the service mandatory training. The training matrix showed that 19 staff had not received training in 'Person First, Dementia Second'. The registered manager contacted us after the inspection and stated that the training matrix had not been updated and that additional staff had received this training. We have not been provided with any additional evidence to confirm this. Other areas of training was not always complete for staff with 20 staff not receiving moving and handling or health and safety training. None of the staff had received training around behaviours that may be challenging despite there being people in the service that had these behaviours. Clinical training was not always up to date with the nursing staff.

The registered manager told us after the inspection that the training around behaviours that challenge was not available to staff until 2016. They confirmed after the inspection that some clinical updated training had been provided and that more was being arranged to ensure that staff were up to date with the guidance.

Staff were not always supported in relation to the work that they carried out. Some staff told us that they didn't feel supported. One said that, since working at the service this year, they had not had a one to one supervision with their line manager. They told us "I don't know whether I'm doing well or not." Another member of staff told us that they didn't have one to ones with their manager and said that

Requires improvement

Is the service effective?

they would like to have them. Staff told us that they didn't always feel that they were listened to or that senior staff acted on the concerns that they had about people who lived at the service. The registered manager told us that one to one supervisions needed to be held with staff six times a year. There were over 60 staff who had not had a one to one supervision with their line manager this year which was outside of the services own policy. There was no opportunity for staff and their line manager to discuss their performance and any ongoing training needs they may have. The registered manager said that they knew they were behind with staff's one to ones and that this was because the focus had been on other areas of the service.

Not all staff received annual appraisals to discuss their performance over the year and further training and development needs. Only five members of staff had received an appraisal with their manager. The registered manager said that they were aware of the lack of appraisals for staff and were working on resolving this.

Staff were not always suitably supported, competent and skilled in their role. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff that had an effective induction into the service. Staff said that they would 'Shadow' staff on the floor before they provided any care. One member of staff told us "The induction was absolutely fantastic, the training was made very interesting."

The environment did not always meet the individual needs of people living at the service. Although there had recently been some refurbishment to improve the environment there were still areas that required improvement. There were very few destination points or signage to help orientate people living with dementia around the service which would assist them with their independence. There were some memory boxes outside of people's rooms to help orientate them but these were not always filled with items about the person so they were not always helpful to people. Some boxes did have items that belonged to the person but others had cuttings of magazines in them which did not necessarily reflect who the person was according to the information in their care plans. We saw people that people did not always know where their room was and some found themselves in other people's rooms which caused distress to all.

The service was not always suitable for purpose of assisting people living with dementia. This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had enough to eat and drink. People told us that they liked the food that was provided. One person said "You get lots of food here, almost too much, I get biscuits and milkshakes. I can even have Horlicks if I want it." Another person said "The food is good and you get a choice." We saw that people were offered food and drink throughout the day.

People at risk of dehydration or malnutrition had effective systems in place to support them. Where people needed to have their food and fluid recorded this was being done appropriately by staff. Intake and output of food and fluid was recorded on forms that were kept in people's rooms so that staff could easily keep an accurate record of what people had eaten and what they had had to drink. We saw that drinks were within reach for people that were in being cared for in bed. People were weighed regularly, in most cases monthly. If there was a change in someone's weight then this routine would be changed to weekly. If staff had concerns they would raise this with the appropriate health care professional.

The chef had records of some of the people's individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. For those people that needed it equipment was provided to help them eat and drink independently, such as plate guards and adapted drinking cups. Nutritional assessments were carried out as part of the initial assessments when people moved into the home. These identified if people had any specialist dietary needs.

People were supported to remain healthy. People had access to a range of health care professionals, such as the GP, dietician, Parkinson's nurse and chiropodist. The GP visited regularly and people were referred when there were concerns with their health. One health care professional told us that staff at the service regularly had contact with the local mental health team. On the day of the inspection the GP visited people at the service to assess any needs that they had. We saw that one person had access to a multi-disciplinary team of health care professionals to support them with their needs.

Inadequate

Is the service caring?

Our findings

Staff at the service were not always caring. There were times during the inspection where staff were not as supportive to people as they could be. One person was left unsupported to walk back to their chair. We saw that staff had encouraged them to start walking and then left them to struggle back to their chair. Another person asked a member of staff for a tissue to wipe their nose. The member of staff handed them a paper hand towel (which was rough) instead of a soft tissue. One person asked us if we could take them to the toilet, we mentioned this to a member of staff who responded "(The person) will ask that all day, they don't need one really."

We observed staff were not always as kind and considerate towards people as they could have been. One person was in their room calling out for help from a member of staff. Staff walked past their room several times and ignored their calls. After 10 minutes a member of staff responded to the person and asked them if they had had a cup of tea without asking them what they were calling out for. The person replied yes and the member of staff responded "Oh well nearly time for lunch" and then walked away again without trying to find out what the person wanted. Another person was calling out to staff and as they walked past asked them a question. Two members of staff who walked past ignored the person's question to them. We saw several times when staff would often talk over people without letting them finish their sentence.

There were times when staff didn't treat people with dignity and respect. One person was brought into the middle of the lounge whilst asleep in their wheelchair in order for the hairdresser to cut their hair. The person remained asleep throughout. There were occasions where staff talked amongst each other and did not interact when people were around them, especially during the meal time. People were left for periods of time not understanding what they were waiting for. People were calling out saying "What's happening" and "What's next." The meal time was chaotic and did not appear pleasant or relaxing experience for some people.

Staff did not always treat people in a caring and dignified way. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these observations people were complimentary about the staff at the service. Comments included "The carers are very good, they are kind" and "Staff are really nice, we are always having a joke, they (staff) make me laugh."

There were times where staff were caring and considerate towards people. We saw staff supporting people to eat in a considerate way and speaking to them whilst doing so. Another member of staff discreetly asked someone if they needed assistance with the toilet before supporting them to do so. One person was looking at someone's memory box, a member of staff stopped what they were doing and stood and chatted to them about the things in the memory box. One member of staff said "The home is caring, I make sure I go over and above."

People's decisions around their care were not always supported by staff. There was some information about people's choices, likes and dislikes but these were not always in any detail and staff did not always adhere to people's preferences. In one person's care plan it stated that they liked to get up between 09.30 and 10.30am . At 11.30am they were still in bed despite telling us that they wanted to get up. One member of staff told us that they didn't always get an opportunity to read through people's care plans as they were stored in the office and relied upon other staff telling them about people. People did not always get information in a format to meet their needs. During meal times people were not offered a visual choice of the meal. This would make it easier for people living with dementia. The registered manager told us that they had been doing this but stopped because they were finding that people were taking the meal from staff instead of staff telling the server what people wanted. They told us that they would look to start doing this again.

One relative told us that they were involved in their family members care and were contacted about any changes that had occurred. Another person told us that they were asked about the care that they wanted. Staff at the service had the details of an advocacy service should people need support to make important decisions. Most other people at the service were supported by family members.

Inadequate

Is the service responsive?

Our findings

People did not always receive care and support that met their needs. We saw that two people with complex needs had been prescribed antipsychotic treatment. There was no information in the people's care on how staff should support these people when they were distressed or on ways to occupy them to relieve their levels of anxiety. For those people who were prescribed warfarin there was no care plan for staff about moving and handling to minimise the risk of skin damage and bruising which is important to people who are receiving this type of medicine.

One person required top dentures, there was no information to staff on whether these had been ordered or how the person was being supported whilst they were waiting for this to be dealt with. The person told us that they were unable to wear the dentures they had because they didn't fit properly. The registered manager told us that they did not know the person wore top dentures as they had never seen them in their mouth. Staff were unable to tell us what was being done to address this however one member of staff did say that they were asked some weeks ago to see whether a set of dentures the person had fitted them. This meant the person had to have a soft food diet due to the risk of choking as they were unable to chew food properly without their dentures in.

One person had been admitted to hospital with a significant injury to their leg. A member of staff had reviewed their care whilst they were in hospital but their care plan did not reflect their most up to date needs. The information for staff suggested that there had no change to the persons needs and that they were able to walk with the assistance of a frame which was not the case. The registered manager told us that they visited the person in hospital to undertake an assessment of their needs but they had not recorded this. Since returning to the service the person needed to be hoisted however staff were unable to get the person out of bed because the correct sized hoist had not been ordered. The registered manager told us that there was no reason why the hoist had not been ordered and said that they would address this however it had been a few weeks since the person had returned to the service.

One relative told us "I feel the home is outstanding and the nurses are excellent." They told us that the staff had responded quickly to their family member's ill health and felt that the family member would not be alive today without their intervention. However there were times where staff responded appropriately to people's care. One person had developed a wound which was quickly identified by staff, a body map was completed and treatment was commenced.

Communication was not always shared between staff which put people at risk. One member of staff told us that they had returned from leave and had not been told about a person who had had two falls. They said that they had noticed that the person was not their normal self but was not aware at the time that this was because they had an injury to their leg. This meant that the person may have been receiving the wrong care from staff because they were unaware of their current needs. Staff told us that communication was not good between nursing staff and the care staff and that information was not always shared about people's up to date needs. The registered manager confirmed this as well and said that they were working on ways to improve the communication and sharing of information with staff. We looked at the handover sheet for the person that had had a fall. There was limited information for staff and stated that the person had 'No injuries' which was inaccurate.

Activities that were available did not always meet the needs of people. On the day of the inspection four people had been supported to go out in the community and we saw one art activity in the afternoon which five people took part in and enjoyed. Despite this there was no evidence of meaningful activities on offer specific to the needs of other people living at the service. There were long periods of time where people had no meaningful engagement with staff. There were no resources to hand to enable spontaneous engagement with people such as objects of interest, books or games. One member of staff told us that often the activities coordinator would be assisting with care if there was a staff shortage which would mean that there was no one supporting activities. One person said to us "Sometimes it gets a bit boring but I do enjoy the exercises" whilst we heard another person say "I think I will go to bed, this is boring." Staff said that there needed to be more for people to engage in. One member of staff said "I think they (people) could do with more interaction, I feel there could be more music." There was no evidence that people cared for in bed had undertaken any meaningful activities.

Inadequate

Is the service responsive?

Care and treatment was not always provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was a complaints procedure in place however the registered manager was unable to demonstrate how people who lived with dementia were able to access this. There was no evidence of a policy that was in a easy read format for people. One person said "Can't complain here, the staff are very nice." Another person said that they would speak to the relative if they had any concerns and the relative would make a complaint for them. The registered manager told us that since taking up post they had not received a single complaint. Compliments from people and relatives were logged and kept for staff to see. We saw examples of compliments which included thanking staff for the care that they had provided.

Inadequate

Is the service well-led?

Our findings

The service did not promote a positive culture and sense of teamwork to drive improvements for the people that lived there. There was not always consistent and visible leadership around the service. We found that nursing staff were not always engaging with care staff much during the day. There were occasions where we found that nursing staff were not encouraging care staff or involving themselves in the day to day care that people were receiving. One member of staff said that they felt that the nursing staff were not on the floor as much as they could be and there was a sense of 'Them and us'. The registered manager told us they had also identified this issue and had been trying to think of ways of making the staff a more cohesive team. On the day of our inspection it appeared chaotic particularly at mealtimes and the staff team did not appear well organised.

One member of staff said "The manager is lovely but has a hard job on his hands." However there were staff that told us they didn't feel supported by the management team. One member of staff didn't feel there was a strong leadership in the service whilst another said that they felt support from the staff but not from management. One member of staff said that although they were aware of the whistle blowing policy they wouldn't feel comfortable using it for fear of being "Ostracised or backstabbed." Staff told us that they didn't always feel valued. One member of staff said "I don't feel valued and I don't get thanked." Another member of staff said that they returned from work from being off sick and said that they were not asked how they were and didn't have a 'Back to work' interview with their manager to see if any additional support was needed.

The registered manager told us that regular staff meetings took place (staff confirmed this) but that they had not recorded them. There was no evidence of discussions that had taken place at any of the meetings.

However there were staff that told us that the registered manager's door was always open and felt that they could go to see them whenever they wanted. One told us "He (the manager) is always very visible and checks everyone is ok, his door is always open." All the staff felt that the manager's door was always open to them. One person told us who the registered manager was and said that they were present around the service.

Effective management systems were not in place to assess, monitor and improve the quality of service people received. The provider's regional team had undertaken monthly audits, actions identified where not always completed to improve the quality of the service provided. For example it was raised on an audit in August 2015 that activities needed to be planned specific to the preferences of people who lived at the service. We found that this was still not being done. In an audit in June 2015 it was suggested that 'Themed areas' needed to be developed for people to encourage stimulation and this had still not be done either. The registered manager told us that they didn't record any other audits around the service and that this was an area they knew they needed to address.

There were concerns around the service that the registered manager was aware of however there was no evidence that these were being addressed by them. For example the registered manager told us that they had concerns that instead of staff hoisting people into wheelchairs when they needed to be moved people were being wheeled around in lounge chairs with wheels on. They said that they were aware that staff were doing this because "It was easier for staff" but to date had not addressed this.

People's feedback about how to improve the service were not always used. Surveys had been undertaken with people, their relatives and staff. However these had not always been used to improve the quality of care for people. The survey for people in June 2015 had also raised concerns over the quality of the activities on offer for people which still had not been addressed. Staff had raised on their survey this year that they didn't feel satisfied that the leadership team was committed to delivering high quality care, we found that this was still a concern for staff. The registered manager told us that another survey had been completed in October 2015 however the results of these were not available to us.

Records were not always accurate and were not always complete. One person's care did not reflect their current needs and there was no evidence of the assessment that the registered manager undertook when they were in hospital. Activities logs for people either had not been written on or were not fully completed. One person's last activity entry was on the 30 September 2015.

Inadequate

Is the service well-led?

Appropriate systems were not in place to assess, monitor and improve the quality of the service, and the records were not always complete and accurate. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had not informed the CQC of significant events in a timely way. The registered manager told us that they frequently sent notifications to the local authority where there was a suspected safeguarding concern. Not all of these had been sent to us so we could not effectively monitor what was happening in the service.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not ensured that people's consent had been gained and their capacity had been assessed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The provider had not ensured that the environment was always suitable for people living at the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider had not ensured that the registered manager had the necessary competence skills and experience to carry out their role.**