Donness Nursing Home Limited

Donness Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

An unannounced comprehensive inspection took place on 16, 29 June and 4 July 2018. It was carried out by one inspector, who was accompanied by an expert by experience on the second day. There was a second inspector on the second and third day.

In 2017, the home had been rated as 'good' by CQC. The appointment of a second registered manager had helped drive improvement in the home. A team of multi-disciplinary health and social care professionals had also provided intensive support to the service to address a previous lack of staff training, poor record keeping and poor management. This high level of support had been instigated when the service was rated as 'inadequate' and 'requires improvement' following CQC inspections in 2016. The second registered manager left shortly after the inspection in 2017 and the outcome of this current inspection shows the provider was unable to sustain the improvements made.

Prior to this inspection, CQC were contacted by two people who raised concerns about the quality of the care at the home and the poor practice of some staff. This inspection was brought forward due to concerns about staff practice and the care at the home.

Donness Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Donness Nursing Home provides accommodation for up to 34 people; 27 people were living at the home during our visit. The service provides care for older people; most people are living with dementia. The bedrooms are on all three floors, which can be accessed by a passenger lift.

A registered manager was in post. 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'. The registered manager is also the home owner. 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. The registered manager is also the provider.

During our inspection, we contacted the local authority safeguarding team and made safeguarding alerts for five individuals because we were concerned about their safety and well-being. Following the inspection, we met with the provider and a group of health and social care professionals, which included commissioners. At this meeting, the whole service met the threshold to be monitored under the local authority's safeguarding process. This meant health professionals began to visit the home on a daily basis to monitor people's care and well-being and to review people's care needs to ensure they were being met. Commissioners have taken the decision not to move new people to the home and the provider has agreed not to admit new people.

Staffing arrangements were poorly planned and potentially put people at risk. Rotas were not organised to provide consistent cover. This was despite people with complex physical and mental health needs and end

of life care needs living at the home. Low staffing levels impacted on the safety of people at risk of falls as communal areas were not staffed in the early evening. People who had been abused by a person living at the home were not protected as staff did not ensure they monitored people's whereabouts or observed communal areas in the early evening.

Staff training was not well managed and systems were not in place to ensure all staff practiced in a safe and caring way. There were examples of good care, with staff showing affection and compassion towards people. However, there were also practices which undermined people's dignity. This was because improvements were needed in staffing levels, skills and knowledge in supporting people living with dementia. People did not always experience meaningful and caring interactions from staff. This was needed to reduce the risks of social isolation and to enable people to feel involved in their care.

Staff recruitment had been problematic, particularly for nurses. There was an on-going reliance on agency staff to supplement the staff team. The same agency nurses usually worked at the home but this was not the case for care workers. There was a core group of staff in different roles who were loyal to the service and who had built good relationships with people living at the home. However, staff said some shifts ran below the registered manager's preferred level putting extra strain on staff in a job which was already demanding.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions, and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection, applications had been made to the local authority in relation to people who lived at the service. However, the local Deprivation of Liberty Safeguards team had not been updated when a person's needs had significantly increased. This meant people's legal rights were not protected. Some applications had been incorrectly applied for. They had not been audited to ensure the applications to restrict people's ability to leave the building were appropriate.

Recruitment practice ensured all the necessary information was in place before staff started work at the home, which included checking nurses were registered with the Nursing and Midwifery Council. However, information linked to people's suitability to work was not addressed as part of their induction and training.

The home was clean but poor infection control practice put people's health at risk. Medicines were generally well managed; although people said nursing staff did not always ensure people had taken their medicines. During the week, social activities were arranged in communal areas but further work was needed to ensure people had their individual social needs met.

The service was not managed well: the leadership of the home was weak. During our inspection, we found a number of areas that needed to improve to maintain the safety and well-being of people that had not been identified by the registered manager. Systems to address previous concerns linked to the safety of people living in the home had not been sustained.

Statutory notifications, required by law, were not always sent to the CQC. These linked to safeguarding concerns and staffing arrangements. This meant CQC was not able to effectively monitor the operation of the service.

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

The overall rating for this provider 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 powers 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. The service will be kept under review and if needed could be escalated to urgent enforcement action.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the 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 or 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. 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 inspect it 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.

Staffing levels were inconsistent and poorly planned. This impacted on people's safety and well-being.

People living at the home had not been safeguarded against the risk of abuse.

Risk assessments were not routinely updated after a change in people's care needs.

The recruitment procedure meant necessary documentation was obtained but there were not clear plans to manage concerns highlighted as part of this process.

People's health was at risk by poor infection control practice. However, medicines were well managed.

Is the service effective?

Inadequate

The service was not effective.

Staff had not been appropriately supported through training and supervision. This impacted on people's safety and well-being.

Protecting people's legal rights and gaining their consent does not routinely happen. Suitable arrangements were not in place to obtain people's consent.

The systems in place to monitor people's food and drink intake were not effective. Therefore people were at risk of dehydration and weight loss.

Premised were well maintained.

Feedback from staff and records showed health professionals were usually consulted when other people's health needs had changed.

Is the service caring?

Inadequate

Many aspects of the service were not caring.

Practices that undermined people's dignity and privacy had not been addressed. Staff whose skills made them positive role models were not utilised to influence other staff members' poor practice.

People were not routinely involved in decision-making in connection to their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was often task focused and did not consider their life needs.

Complaints were not well managed.

People who stayed in their rooms did not benefit from activities that met their individual interests.

People were not involved in decisions relating to their end of life care needs or wishes.

Is the service well-led?

Inadequate

The service was not well-led.

People's health and well-being were at risk because the registered manager/provider had not maintained the improvements made in 2017.

The registered manager had not ensured that there were systems and leadership in place to effectively monitor the culture, quality and safety of the services provided.

Statutory notifications, required by law, were not always sent to the CQC. This meant CQC was not able to effectively monitor the operation of the service.

Donness Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 19, 26 June and 4 July 2018. This inspection was brought forward due to concerns about staff practice and the care at the home. Three inspectors and an expert by experience undertook the inspection. An expert-by-experience is a person who has personal experience of caring for someone who living with dementia.

Prior to the inspection, we reviewed all the information we held about the service. This included notifications we had received. A notification is information about important events, which the provider is required to tell us about by law.

We met all of the people who lived at the service and observed staff interactions with them in communal areas of the home. We met people who lived at the service and received feedback from seven people who were able to tell us about their experiences. Some people using the service were unable to comment on their experience of life at the home. We spent time in communal areas observing staff interactions with people and the care and support delivered to them. We used the Short Observational Framework for Inspection (SOFI) in the unit. SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We spoke with four visitors. We looked in detail at six people's care records.

We spoke with eleven staff, which included the registered manager, with a range of roles. We looked at the staff files for eight staff which contained training and training information. We looked at the provider's quality monitoring systems which included audits of medicines and safety checks for equipment.

During the inspection, we shared our concerns with the local authority safeguarding team, commissioners and clinical commissioning group who began action to review people's care.

Inadequate

Is the service safe?

Our findings

Staffing arrangements were poorly planned and potentially put people at risk. We were provided with contradictory information from staff and the registered manager regarding how nursing arrangements on one shift had been managed. The staff rota had not updated by the registered manager before they went on holiday and therefore was not accurate. Staffing levels did not always meet the needs of the people who lived at the home. A staffing dependency tool was in place but it had not been completed correctly and therefore was not an accurate tool to use to assess staffing levels. For example, a person with multiple health issues, needing two people to move them in bed and receiving end of life care was scored as low dependency.

Staffing arrangements were not organised to provide consistent cover despite people with complex physical and mental health needs living at the home. This meant some shifts in the afternoon were below the provider's preferred level of four care staff and one nurse, plus a hospitality staff member. For example, one rota showed in one week there were five afternoons with only three care assistants to work alongside the nurse. This included a staff member who was new and had been assessed as needing to work in a pair with a more experienced member of staff because of the level of spoken English. This arrangement was not due to staff sickness but had been planned.

A staff member said, "We need four staff in the afternoon, three is not enough." They were referring to care workers. Another staff member said it was "heavy work with a low ratio of staff." A third staff member commented low staffing and a turnover of staff reduced staff morale. Records showed people's care needs were the same during the weekend but there were less staff on duty. Staff were often too rushed at mealtimes to engage with people in a meaningful and safe manner. A visitor said the standard of care was "hit and miss."

In the late afternoon, care staff were busy supporting people to return to their rooms, while the nurse administered medicines. This meant care staff were working over three floors of the nursing home and regularly had to work in pairs for people who needed additional support. For example, the registered manager said 13 people needed two staff members to move them. Staff confirmed this number but also added an extra person whose needs could be variable.

Staffing arrangements impacted on the management of risk for people who had chosen not to go to bed after teatime. For example, staff were not in communal areas of the home as they were providing care in people's bedrooms. Two people who were assessed as high risks of falls were restless, either walking about or standing and changing position. One person's care plan stated "Staff must observe her for safety." For 35 minutes there were no staff monitoring this communal area.

Ten care staff had been in post for over 12 months; four care staff were newly appointed. Several staff members commented on the recent turnover of staff who had only stayed for a short period of time, which records confirmed. More experienced care staff worked alongside newly recruited care staff. They said it could be demoralising having a person shadowing their practice then quickly leaving the service. Some were

concerned about the suitability of some staff for their role, particularly around their communication skills. The registered manager said they were recruiting to replace care staff who had recently left. Staff said they would like to be updated more often about the progress of staff recruitment and the steps being taken to recruit. They said this would reassure them.

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

A nurse worked on every shift; the registered manager is a nurse and worked shifts. During the week, a nurse was usually supported between four and five care staff in the morning, which included an overlap with care staff at lunchtime who arrived to work the afternoon/evening shift. A member of the hospitality team also worked on each day shift to assist with meals and drinks. Despite this increase in staff at lunchtimes, care staff were too busy during one midday meal to provide the appropriate level of support and encouragement to people who were less able or reluctant to eat.

Since the last inspection in June 2016, there have been changes amongst the nursing staff with three new staff members joining the home in early 2018. Registered nurses from local nursing agencies covered vacant nursing shifts and where possible the same nurses had been provided to promote continuity for people living at the home. Rotas showed agency nurses working at the home were consistent for a ten week period, which staff confirmed; they usually covered one shift a week. However, rotas showed there was less consistency when agency care assistants were used; with seven different staff in four weeks. This meant people were being assisted with personal care by a range of staff, who they had not met before.

We were told the induction for agency staff had mainly fallen to other staff to complete a verbal handover of people's care needs and a verbal induction, including a tour of the building and fire safety. There was no written record for agency staff to refer which summarised people's care needs.

Since our last inspection, a new call bell system had been introduced, this enabled staff to locate each other, which addressed previous concerns of staff being unable to contact one another in a timely manner.

People were not protected from harm. Staff reported one person's actions put staff at risk of harm. We looked at the person's care records and saw they had abused people living at the home, both physically and sexually, leaving people distressed and needing reassurance.

People were not protected from abuse as staffing arrangements meant communal areas were left unsupervised. This left a person alone with another person, who had abused them in May and June 2018 by kissing and embracing them in a communal area without their consent. Records stated this left the person shaking, visibly distressed and shouting out for help. Risk assessments had not been updated despite one person's care plan identifying some of the risks they posed to others. Steps had not been taken to protect other people living at the home; we made safeguarding alerts for five individuals to the local authority.

Some people told us they did not feel safe in the home. For example, one person said this was because someone uninvited came into their room and had hurt them. A staff member who was with us queried their account of their hands being bruised and seemed frustrated they had broken a number of call bells. An alternative type of call bell had not been provided. We saw from records the person they described matched one of the people living at the home. Records showed the person did go uninvited into people's rooms, and sometimes pulled off bed covers; the person could also be reluctant to leave. We have other examples from people who did not feel safe.

Care staff said they understood their responsibility to raise concerns about abuse and poor practice. For example, "If I saw anything I would do something about it. I think they are well looked after, we have residents who come here on respite and keep coming back." However, one staff member could not describe abuse and was unclear of when they would report concerns. Some staff members reported they had raised concerns with the deputy manager and the registered manager about poor practice in the home. They were unsure if action had been taken to address their concerns. We looked at the staff records for a named staff member but there was no documentation about how concerns had been addressed with them or monitored.

Incidents of poor practice were not investigated. A person contacted CQC with concerns about the actions of some staff at the home, including being 'rough' when supporting people. Care records showed an incident where a person had been harmed whilst staff were assisting them to undress. The information on the incident report did not match the daily notes. There was no formal acknowledgement of the incident or if steps taken to prevent an injury happening again. This meant the incident had not been thoroughly investigated and measures had not been put in place to help prevent further incidents.

These examples are a breach of Regulation 13 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

In contrast, a relative said "It's knowing Mum is in a safe and secure building now that lets me sleep at night" and a person living at the home said "I feel very safe, I think – on the whole."

Some environmental risks were not managed effectively and put people's safety at risk. For example, the hot water in sinks in communal bathrooms were not monitored. The hot water was too hot which compromised effective hand washing and had the potential to scald. Staff could not remember a recent fire drill; records could not be found for 2018. This could mean if there was a fire people's lives could be at risk through lack of staff training to act in a competent and confident manner. The registered manager took action to ensure a drill was carried out the day after the inspection.

Identified risks to people's health were not always managed effectively with poor guidance to staff. For example, there was no information for care staff as to what to do if a person assessed as at risk choked. We highlighted this to the registered manager who confirmed after the inspection this information was now in place. The registered manager had not identified or planned what type of training a new staff member would need despite them not working in social care before. A colleague had shown them how to prepare food for people at risk of choking but this had not been formally discussed or arranged as part of their induction.

At the beginning of the inspection, we were told no one needed to be on a food and fluid chart. The registered manager said they were confident staff would tell them if this was needed. We reviewed a list linked to breakfast arrangements; they were inconsistently completed. For example, on one day out of ten people, nine had been given a drink. On the next day, the list of twelve people showed no drinks had been given. We queried this with a staff member who suggested people often said 'no' to a drink, they did not seem concerned. We were therefore not confident how people's fluid intake was monitored. However, records showed people received their food supplements as prescribed by a GP.

Two relatives said they kept daily records of their visits as they had concerns about the quality of care; one said they had to visit daily to ensure their relative got the care they needed. They worried staff checked on them in a superficial manner and therefore did not take the time to ensure they had a meaningful response from their relative.

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

On our second day of inspection, the settings for pressure mattresses were not recorded on paperwork in people's rooms. Staff said they checked the setting but this was ineffective as records did not show what the setting should be. Staff said they were now checking the setting of pressure mattresses on a daily basis; a staff member was training staff on the third day of our inspection. Those we checked correlated with people's weight. Moving and handling equipment had been serviced at appropriate intervals.

People were at risk of cross infection. This potentially put their health at risk. A person contacted CQC with concerns about poor infection control practice at the home by some staff. We saw poor practice by a staff member who did not wear gloves whilst handling soiled items and did not wash their hands. There were poor quality gloves for staff use; we saw they were only one size and were not robust. Health professionals advised the registered manager their explanation for their use was not safe and could spread infection. There was no nominated infection control champion in the home to establish and monitor effective systems. A previous system had been set up to wash slings used to move people with a hoist and to clean mattresses but was ineffective as slings were not washed regularly.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was clean; there were no on-going malodours. However, one person said their first bedroom had smelt unpleasant when they moved in; they were moved to another room. One visitor said their relative's en-suite was not always kept clean. In contrast another visitor said the home was always clean and odour free. Cleaning staff were clear about their role and their duties.

Recruitment procedures ensured necessary checks were made before new staff commenced employment. For example, disclosure and barring service checks (DBS). The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. Recruitment files included references and appropriate checks. Disclosure and Barring Service (DBS) checks were completed. Records showed the registered manager checked the registration of nurses being recruited to work at the home. However, action was not recorded of how concerns from references or application forms had been managed. For example, one person's application form and a reference raised queries about the person's suitability for their role, which had not been addressed as part of the recruitment process. This put people at potential risk of receiving poor or unsafe care.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were well managed, apart from a concern raised by two people. One person said staff did not always check they had taken their medicines. They said "I don't think that the tablets should just be delivered by a kitchen assistant when they bring a tray of food for me to eat in my room." A staff member said people living with dementia were left unsupervised to take their medicines by some staff. This practice was not seen during the inspection; staff administering medicines checked people had taken them. We checked people's medicines and found that all doses were given as prescribed.

Staff completed a medication administration record (MAR) to document all medicines taken so all doses were accounted for. Only nurses administer medicines. Relevant staff had signed the medicine policy to say they understood the policy and procedures. A local pharmacy visited the home to collect disposed

medicines on a monthly basis and delivered prescribed medicines. They also provided training in the home plus on line training and completing a booklet. Systems were in place to check in and dispose of medicines. Information was available linked to allergies, covert medicines, as required medicines and storage temperatures were monitored.

Inadequate

Is the service effective?

Our findings

The registered manager could not demonstrate how and if the competence of staff had been assessed or maintained. Staff training and their competency was poorly monitored. Staff did not receive on-going supervision or regular training. Staff feedback and the lack of records in their staff files confirmed this to be the case. New staff members' competency was not assessed; this meant the registered manager could not evidence their practice was safe or based on current and best practice.

There was no overview of staff training. The registered manager had not addressed that some staff attended less training than others. For example, one staff member had not completed training pertinent to their role, such as moving and handling, safeguarding or infection control courses. Observation of their practice evidenced a lack of training in infection control. Staff were selected to attend training because they were not on duty on the day that training was to be delivered. Staff said they were not paid to attend training. It took place during their time off, which they said had not been made clear in their interview. A staff member said this made it difficult to take disciplinary action if staff did not attend training.

Attendance levels were low for free external staff training with some sessions cancelled by the management team due to low staffing levels. The local hospital had also provided training on a medical intervention, which related to the care of a new person moving to the home. All the nursing staff attended, apart from the registered manager. They said they had attended training at another time. However, they had not gained consent from hospital health professionals to roll out this training to non nursing staff. Neither had they checked with commissioners if they were in agreement for non-nursing staff to perform this complex care intervention, despite the commissioners funding the new person for 24 hours nursing care.

Key training had not been organised in a timely manner, for example practical moving and handling training. The last session was in April 2017. This meant six current staff members had not completed this practical training despite 13 people needing two staff members to assist them to move, which involved using equipment. Staff practice showed training was needed; we saw poor practice by a number of staff members. For example, a person using a wheelchair was not asked before their feet were lifted off the footplates for them. A few minutes later, the person was pushed up to the table, again without being told what was happening. Their feet were dragged under the wheel chair causing them discomfort. This went unnoticed by the staff member pushing them.

On another occasion, a person looked scared and called out "Oh my God" as they were being hoisted; staff did not take time reassure them. We saw records of two incidents in 2018 when people had been injured whilst being moved by staff, resulting in a "large skin flap" for one person. This was treated at A&E. During the inspection, we shared our concerns with the registered manager as people's safety was at risk because of poor practice. They said they would book practical moving and handling training. As part of the safeguarding process, health professionals visited to instruct staff on safe practice.

The registered manager could not demonstrate how they ensured nursing staff maintained safe medicines administration practice. Only nursing staff administered medicine; a new staff member's medicine practice

had not been observed or assessed since joining the service.

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

People's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005 in relation to consent. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. However, there was no record of best interest meetings for two people who had been moved from single bedrooms to a shared one. Staff said one person's family had been consulted despite not having the legal power to make health and welfare decisions; there was no record of this consultation. The second person had been moved to the room without advising the local authority who were funding their stay at the home. The local authority does not routinely fund shared rooms.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. DoLS applications had been made for some people living at the home.

Staff did not have the necessary skills to make a judgment about people's capacity to consent. For example, one person repeatedly tried to open the front door and became frustrated. An urgent assessment had not been requested and staff did not consistently follow the advice in the person's care plan in order to diffuse the situation. The registered manager told us during the inspection as urgent application would now be made.

In one person's care plan it was recorded the person would like to be asked before information was shared with a relative. Records showed information had been shared without their consent. Following feedback at the inspection, the registered manager met with them to discuss when information could be shared.

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

The wording in care plans stated people should be involved in decisions but people's daily records did not routinely indicate people had consented to care. Most staff in their conversations with people checked how they wanted to be supported. However, there were times when staff were directive in their approach. For example, several people moved around communal areas and some staff would ask people where they were going and encourage them to sit back down. On another occasion, a staff member recognised from the actions a person living with dementia that they did not want an apron on to protect their clothes and took it away. A second staff member then just placed the apron over the person's head without speaking to them or giving them eye contact and walked away.

People's health care needs were not consistently met by staff despite knowing about their care and treatment needs. For example, a visiting health professional advised staff a person needed to eat and drink straightaway due to their health condition. Staff ensured food and drink was served but did not supervise the person who was left alone in the dining room, with their breakfast half eaten. The person said "I just sit here and nobody speaks to me"; they told us they needed the toilet. Staff assisted them but then took them to a lounge, leaving their drink and breakfast in the dining room. We informed the registered manager straightaway because the person's health was at risk and advised they needed to take immediate action to

ensure they had eaten, which they did. Staff commented how the person was difficult to rouse and seemed sleepy. Later in the day, a visiting health professional confirmed the person had improved.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Feedback from staff and records showed health professionals were usually consulted when other people's health needs had changed. This was particularly the case for one person whose behaviour impacted on the safety and well-being of others. However, the registered manager said they had not felt supported by one of the GPs at a time of crisis for one person.

There were some positive comments from people about their care. A person living at the home said "I just need to let them know if I'm unwell, or if I don't think my dentures are right, or anything like that. Then they will know who to talk to, and get me sorted. If I ask, they'll book an appointment for me, or whatever I need." A visitor whose relative had recently moved in said "Mum is so well looked after here. If she is feeling unwell I can ask for them to let the district nurse know, or they will just arrange for her to be seen and let me know if it's a bit more urgent. They take such good care." Records were kept of agreed action, such as requesting a GP to visit. Care staff said they were kept updated and knew their responsibility to report changes to nursing staff, which a nurse confirmed. Staff worked with local healthcare professionals such as GPs. This was demonstrated through advice recorded in people's daily notes and actions by nursing staff to advise GPs of changes.

However, it was not always easy to track back how and when changes to people's care had been decided and by whom. This was because professional advice was not consistently recorded on the forms in files. Instead, sometimes it was amongst the daily notes. This meant it was difficult to establish patterns and a clear timeline of decisions resulting changes to care.

Staff handovers took place before each shift. The quality of nurse handover records varied; some had gaps and did not provide an audit trail. For example, a nurse had not ensured their colleague was aware of a malfunctioning pressure relieving mattress. Fortunately, a care staff member raised it as a concern from the previous day and then the nurse checked action had been taken to replace it with an alternative. A staff member gave examples when information was not passed on in a timely manner, for example updating staff when a person had died or when a new person had moved in.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Meals were not a social occasion and choice was not promoted. At lunchtime, there was one main meal, although catering staff said they knew each person's food likes and dislikes and gave examples when they would produce an alternative. For example, they would prepare an omelette or jacket potato instead. A person said "I've never been given a menu as such, but I can ask for things if I would like them and sometimes they can do them for me... I thought they might offer a choice or vary what they serve (for breakfast), but now I'm just brought cornflakes every day without being asked again."

There was a lack of clarity to the purpose of records relating to breakfast, which mean they were ineffective. Staff gave us variable explanations of the purpose of the list and several raised concerns there was an expectation for some people to be washed by night staff before 7.30 am and have their breakfast in their room. We checked the list which had two different formats, one was poorly completed with gaps, and the second format showed one person had been missed off on one morning. Staff said they were sure breakfast

had been served to the person. We observed there was disorganised communication between staff, which led to the kitchen staff checking and re-checking if a person had been given their breakfast.

People were weighed, although the book used to record weights had no system to ensure everybody had been weighed. We looked at individual people's records and saw their weight was either stable or being monitored, with a referral to the GP if there were significant concerns.

People gave varied feedback on the food. For example, "I didn't like the food. They have a new cook, who is a lot better; I am enjoying the food a lot better." People said "The meals are good and I've no complaints on that score" and "The cooks make nice meals, and there are sandwiches if a big meal is too much." A visitor said "The food presentation isn't what you might expect at home but it's plentiful and although there's not much of a menu to choose from I don't think Mum minds as long as it is easy to chew."

The design of the building did not always support people's independence. Most bedroom doors were only numbered with no names or features to help people distinguish one room from another, although the registered manager said there were personal objects displayed for three people to help them independently identify their room.. Some people had difficulty remembering the number of their bedroom.

In the dining room space was limited; staff squeezed past people or adjusted peoples' positions without their consent. This was often done without warning, causing brief moments of alarm for people whose chairs suddenly moved. A person asked what the main course was but staff were unsure; people were not told what they were being served.

Inadequate

Is the service caring?

Our findings

Some staff practice undermined people's dignity. Lack of regular staff supervisions, observations of staff practice and team meetings impacted on the quality of care provided. Most people were not able to comment directly on their care so we went spent time in communal areas to help us understand their experience. We saw people being moved in an undignified manner, for example when a hoist was used and slings were placed under people. A screen was not used to maintain the person's privacy. At one point, four staff gave instructions at the same time, some of them in an abrupt unsmiling manner, whilst they were moving a person with equipment. One person clapped their hands at them to get their attention. The person looked confused and had difficulty understanding what they were supposed to do. One staff member's approach was kind and considerate, trying to cover a person's legs but their example was not followed by others.

During a lunch time meal, one person asked twice for some salt for their meal but was told by a staff member "The salt hasn't been brought down today" and "I'd have to go upstairs for it so please eat your meal without it." Another person was encouraged to eat their entire main course before their dessert was served; this meant they were not treated as an equal by staff. For example, delaying serving pudding until they had eaten their main course. A few minutes later the same staff member said "You can have cheesecake, but try to finish this first." Some staff discussed people's care needs and habits in the dining room, including a person's medicines, which did not respect people's privacy.

There was a lack of oversight and planning during lunch times so staff practice became task orientated rather than staff considering the potential for meals to be a sociable and enjoyable experience. For example, there were insufficient staff to assist everyone who needed help to use their cutlery on a one-to-one basis. To cope, staff flitted between a number of people and had no time to chat, talk about the food or explain what they were doing. For example, one staff member stood over people as they assisted them, hovering with a loaded spoon in front of a person's mouth while they were still chewing the food in their mouth. They did not offer them a drink. The only word they spoke to another person was "Finish." They did not ask people if they could assist them. On a different day, staff worked hard to ensure people ate their meals and consumed their drinks without spilling them. However, they compromised people's dignity in the process because their approach was task orientated and sometimes rushed.

People commented on the approach of some staff which undermined their dignity. For example, "When the carers get me up in the morning they just walk straight into my room. It's just 'Hiya' as they come in, and mostly they follow up with 'Are we getting up today?' Honestly. Are we getting up? So, I sometimes reply 'Well I'm getting up; you're already up'. I guess they know they should knock first, really."

A person contacted us to raise concerns about the time people were assisted to get up which was at a time to suit the staff rather than their choice. The registered manager assured us this was not the case. They said a breakfast list was used to ensure people were ready for breakfast and to monitor how long they had to wait to be served.

Two visitors raised concerns about the quality of interactions by care staff when they checked on people who spent long periods in their room. They said some care staff interactions were brief and they did not take time to engage with the person to make their communication meaningful. They were unsure if this was linked to low staffing levels or some staff members' lack of training in person centred care or a lack of compassion.

Care plans were written in a personalised and person centred way but the culture of the home meant this was not translated into some staff practice. One person commented "There's a routine you need to fit into here" which they interpreted was for the benefit of staff rather than people living at the home. They gave the example of timing of baths which were in the morning when more staff were available and on set days.

There was a list called a 'Bath Rota' which included the weekends. People told us they were not offered a regular bath, which records confirmed. For example, three people had one bath per month, not weekly as suggested by the rota. Several people said they would prefer a shower as they did not feel safe in a bath but this was not available. A staff member said a shower would help provide personal care for people who experienced significant incontinence. We met one person who was very distressed after their morning bath; this was not captured in the daily notes which just said "X well this morning, assisted with bath." This indicated a lack of recognition by the staff member of the person's experience.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In contrast to the above examples, we also saw many kind and caring interactions between staff and people living at the home. For example, staff welcoming a person after a short stay in hospital. They chatted to them about the football and the person was relaxed at ease with staff; they told us staff were "really good." A relative said "I have power of attorney and the staff involve me in everything. They'll call me if there is anything and ask my opinion. They know I know mum best. They have her best interests at heart. Mum also feels the cold very badly but the staff know that and keep her warm by helping her put a blanket over her knees or offering her a jumper even when everyone else is taking theirs off."

There were some strong role models, and one staff member said they had learnt so much from a senior member of staff. A person living at the home turned to the senior member of staff and said "You are a kind girl" and patted her hand. The staff member thanked her and gently touched her shoulder to give her reassurance. They chatted as they waited for the lift. Another staff member had a kind and gentle approach with people but did not appear to have the confidence to correct other's poor practice, despite showing concern on their face when they saw poor practice.

Written compliments were kept by the provider. They included comments such as "He was in the best hands with you all" and "We really appreciate the love, care and attention you gave to (X)."

Requires Improvement

Is the service responsive?

Our findings

There was mixed feedback from people about how confident they felt to complain. One person told us they were fearful to speak out about poor practice at the home; they felt there could be negative consequences from certain staff members. For example, delays in helping them to bed. We have shared their concerns with the local authority safeguarding team. Other people said that they would feel very comfortable raising any concerns about anything that worried them to any member of staff. Three people and a visitor said they could and would go straight to the owner or manager with any complaint if they thought it necessary. They also said they would probably prefer to talk to staff in the first instance. Some people said that they could not remember having to actually complain about anything because they just needed to ask and something would be done.

A relative told us they had complained about dirty linen, the smell of the home, and the unkempt appearance of their spouse during his stay in early 2018. At the time, they had not been referred to the registered manager and were unaware that the deputy was not the home's manager. The registered manager informed us they had since received a written complaint from the relative, which they had responded to promptly. We asked the provider to send a copy of the original complaint letter which they have not yet done.

At the last inspection a log book had been introduced to record complaints; we reviewed the complaints log for the service. A visitor told us they had been unhappy about a number of issues relating to their relative's care and dignity, which they had reported to staff. On one occasion, they said the registered manager had verbally apologised. The visitor said the management team had not referred to the issues again and had not updated them on what action would be taken to prevent a repetition. We checked the records in the log book. They stated a meeting had been held with staff to discuss a way forward. Staff said the outcome was recorded elsewhere; they gave us the appropriate notebook but it was blank. Therefore, there was no evidence of lessons being learnt from the complaint.

People's care was often task focused and did not consider their life needs. People's care needs had been assessed based on a range of information and each person had a care plan. People's care plans provided personal information but not all staff were aware of this key information to engage with people. For example, one staff member said a person did not respond to music or show an interest. This was despite music being central to their earlier life and information in their care plan. In contrast, a second staff member said the person had responded well to music specific to them.

There was a high level of detail in most people's care plans which contained information was individual to each person. For example, one person tried to regularly open the front door, which was locked. There were clear directions to staff as to how manage this situation in a calm and caring manner. Most staff who carried out a variety of roles in the home followed this advice. But this not always the case, for example the person said "Can you open it?" and pointed to the front door. A staff member responded in an abrupt manner "No, definitely not, it's not supposed to be open" and told them to come away from the door, which left the person frustrated. Another staff member told us the person did not really want to leave the building; this was

despite an incident when the person had accidently left the building and became distressed when asked to come back inside.

We highlighted to staff how one person's care plan was not to the same level of detail as others; they said the registered manager had been previously made aware of this discrepancy. The registered manager said they would address this; as they were the only staff member who wrote care plans.

Not everyone living at the home benefited from meaningful ways to spend their time. Activities were the responsibility of one staff member who worked five days a week. They described how each month had a day devoted to a particular theme, such as American Independence day. This occurred during the inspection and a quiz took place covering a broad range of topics. Later people tried a wide selection of American drinks, snacks and sweets and ate a teatime meal which included hot dogs. A few people were able to participate in the quiz; staff also joined in. Other communal activities included external musicians and singers. During the inspection, a staff member sat with people on the balcony and read to them. On another occasion, they encouraged people to exercise and engage with each other by batting a balloon to one another. The registered manager had met with the staff member to discuss introducing new themes and events. Minutes showed they had praised their contribution and their work.

We recommend that the service seeks advice and guidance on developing activities for people living with dementia.

Some people said they preferred to stay in their rooms but were invited to participate in communal activities. A staff member said it was difficult to meet everyone's individual social needs. They said they stayed and chatted to people who declined communal social events but did not record this interaction. One person who chose to stay in their room was described in their care plan as "enjoys chatting and can be very sociable." We heard them calling out "Hello, hello!" from their room. A staff member was not concerned, they said the person often did not know they were calling out and seemed surprised when staff popped in to see how they were. The person's care plan said their regular use of the call bell could be because the person "needs company or confirmation that someone is around."

We recommend that the service seeks advice and guidance on developing activities and social interactions for people who chose to stay in their own room.

The registered manager and staff confirmed there was nobody currently being supported with end of life care. In people's rooms there was leaflet to help people consider advance decisions for end of life care. Staff training records for four staff members did not include training specifically in this area of care, although people had regularly been supported with this type of care at the home. A staff member said end of life care had an impact on staff members' workload because of the need for hourly checks but additional staff were not put on the rota.

One person's care plan said 'end of life with a poor prognosis'; they were aware of their prognosis. Despite this information, no end of life planning had been completed with them, which we highlighted to the registered manager. They said monitoring forms would be put in place when they became more unwell but they had not considered involving them in planning. A GP was recorded staff were doing "a great job." Another person who been admitted for end of life care was now receiving palliative care, which the registered manager said resulted on the quality of care they received

We looked at how the provider complied with the Accessible Information Standard (AIS). This is a framework put in place from August 2016 which made it a legal requirement for all providers to ensure people with a

disability or sensory loss can access and understand information they are given. Care records contained clear communication plans explaining how each person communicated and ensured staff knew what aids people needed to help them stay involved in the life of the home. However, not all staff recognised effective communication as an important way of supporting people to aid their general wellbeing.

Inadequate

Is the service well-led?

Our findings

The leadership of the home was weak. The registered manager worked nursing shifts; they did not focus on how the home was run. There was a lack of oversight so standards had dramatically declined since out last inspection in 2017. In 2017, the home had been rated as 'good' by CQC. The appointment of a second registered manager had helped drive improvement in the home. A team of multi-disciplinary health and social care professionals had also provided intensive support to the service to address a previous lack of staff training, poor record keeping and poor management. This high level of support had been instigated when the service was rated as 'inadequate' and 'requires improvement' following CQC inspections in 2016.

Since the CQC inspection in 2017, the second registered manager had left the service. Some staff said they regretted the systems to support them were no longer in place. A staff member said the level of support had slipped. For example, they had received regular meaningful supervisions but this was no longer the case. They expressed how they felt their views were not valued; one said staff had good ideas and wanted to make things better but they are not listened to. Another staff member became tearful when we commented on their kind and caring approach and shared positive feedback from a relative. They told us they felt their role was not valued so they just persevered to work in a kind and compassionate manner. They said supporting people "takes as long as it takes" commenting people cannot be rushed. A relative commented that other staff could learn from the staff member because of their respectful and person centred approach.

There was a lack of clear leadership as to who managed the home and made decisions in relation the running of the service. Some visitors to the home said they had mistakenly thought the deputy was the home's manager so had gone to them with concerns rather than the registered manager. They were not always satisfied with the response and the lack of follow up to ensure improvements had been sustained. A person living at the home said they were "never sure who was making the decisions." Staff members said they had reported practice issues to senior staff, but were not confident these had been followed up and addressed by the registered manager. Staff said they did not go to the registered manager but usually reported concerns to senior staff. Records were not kept of the concerns or complaints raised by staff.

Systems to address previous weaknesses in how staff were supported had not been sustained. For example, regular staff supervisions, observations of staff practice and spot checks had not been maintained. Time had not routinely been set aside to allow staff space to discuss their training development needs, as well as time to express concerns or share practices that were working well. Due to the lack of supervision arrangements or appraisals for staff, the registered manager could not formally show how they monitored the quality of care at the home. They said they worked alongside staff in their nursing role which enabled them to informally monitor staff practice. However, they had not addressed some of the issues which undermined people's dignity or safety when equipment was used.

The registered manager could not demonstrate how they monitored staff practice on a regular basis to ensure the approach and skills of the staff were based on current and good practice and met the range of needs of people living at the home. For example, gaps in staff training had not been addressed, the allocation of training was based on staff availability not training need and action was not taken if staff did

not attend training.

Systems to address previous concerns linked to the safety of people living in the home had not been sustained. For example, previous work to improve infection control practice had not been embedded. For example, the registered manager was promoting unsafe infection control methods and poor quality equipment. A lack of effective monitoring of how staff worked resulting in poor practice. The registered manager had delegated tasks to other staff members; they had not ensured these had taken place or been completed effectively. For example, fire drills and fire training were not run at regular intervals and some deprivation of liberties applications had not been completed appropriately and in a timely manner when people's circumstances changed.

There was ineffective oversight of staffing arrangements. Staff told us the registered manager audited the rotas and how sickness was managed. However, when staffing levels ran under the registered manager's stated preferred levels or when arrangements had not been made to cover staff sickness; these had not been addressed by the registered manager. The communication between staff and the registered manager was not always effective, resulting in conflicting explanations as to who was responsible for poor staffing arrangements.

Weak systems meant there was not an effective process to gather people's views and feedback on the service. Care plan reviews did not record how people using the service had contributed to them. Residents' meetings did not take place regularly: there had been none in 2018. Opportunities to engage with people so they could participate in the running of the home had not been considered. For example, to discuss menu changes when a new cook was appointed. A survey to relatives and visitors had resulted in a poor response according to the registered manager; alternative ways to engage with people visiting the home had not been put in place. The registered manager said a staff member was due to send out a survey to people living at the home.

Records were not audited and therefore people's experiences were not reviewed and problems were not addressed. For example, we checked how long a person had to wait for their breakfast to be served in 20 days, generally it was within ten to twenty minutes but there were three occasions when it was over fifty minutes. There was no record to show these times had been audited to ensure people had their breakfast in a timely manner, which made them ineffective.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Maintenance of the building and equipment took place, which included safety checks and servicing contracts for fire safety equipment and lifting equipment. Feedback from staff and records showed health professionals were usually consulted when other people's health needs had changed.

Statutory notifications, required by law, were not always sent to the CQC. This meant CQC was not able to effectively monitor the operation of the service. Notifications had not been made to CQC regarding safeguarding events. The registered manager had not submitted notifications to CQC to cover all notifiable events in the home, such as staffing arrangements. During the inspection, we reminded the registered manager of our previous discussions relating to repeat breaches of this regulation. Abuse had not been reported to CQC which is a regulatory requirement, or the local safeguarding team. This meant the opportunity for other agencies to intervene earlier to protect people was missed.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2010 because CQC had not been notified of incidents within the service.