Caliburn (Care Homes) Ltd

Green Park 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 14 January 2015 and was unannounced. Green Park is registered to care for up to 30 older people with nursing needs. There is a passenger lift to assist people to the upper floors and the home is located close to a pleasant park area and transport links.

The home did not have a registered manager in place. The home had been without a registered manager since 7 May 2014. An acting manager without clinical expertise was overseeing the care at Green Park but was the registered manager for another service. 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.

People told us they felt safe at the home. Risks to people were assessed and acted upon though there was not always sufficient emphasis on how to maximise freedom. Staff were trained in safeguarding and understood how to recognise and report any abuse.

Summary of findings

Staffing levels were not always sufficient to care for people safely or to enable all people to pursue interests of their choice. You can see what action we told the provider to take at the back of the full version of the report.

Staff were not supervised effectively or frequently enough for them to feel supported or to develop professionally. You can see what action we told the provider to take at the back of the full version of the report.

The acting manager, provider and staff were clear about their responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, people who required a mental capacity assessment did not have one recorded, which meant it was not clear how people's capacity to make decisions was supported or promoted. You can see what action we told the provider to take at the back of the full version of the report.

Staff told us they sometimes used pictorial prompts as an aid to communication. However, people's needs related to dementia care were not always clearly addressed. There was little in the environment to support people with a dementia related illness, although staff told us that a number of people had needs relating to this area. You can see what action we told the provider to take at the back of the full version of the report.

The provider had identified a number of shortfalls and had a plan in place to address these; however, there were insufficient systems in place for monitoring the quality of service. This meant that required improvements to care and practice may not be identified or put into place. You can see what action we told the provider to take at the back of the full version of the report.

Medicines were handled safely, however, because the medicines took a long time to administer people did not always get them on time.

People told us that staff understood their individual care needs. We found that people were supported by staff who were well trained. All staff received mandatory training in addition to specific training they may need and a plan was in place for updates to this.

The home had links with specialists and professional advisors and we saw evidence that the home sought their advice and acted on it.

People's nutritional needs were met and they received the health care support they required. However, choice at mealtimes was not promoted. An observed mealtime was relaxed and people received respectful attention, however, nobody had the opportunity to use the dining room which may have enhanced the social dining experience.

Staff had developed positive, respectful relationships with people and were kind and caring in their approach.

Care plans had a detailed clinical basis, however, they did not emphasise people's interests, who and what was important to them or their priorities for care. This meant that people could not be sure that they received personalised care.

People were not sufficiently assisted to take part in activities and daily occupations which they found meaningful or fulfilling. People were at risk of being bored and under stimulated. We did not see any staff use aids to assist people who had a cognitive impairment to make choices.

If people raised concerns or complaints these were usually dealt with promptly and recorded with actions.

Staff and people who lived at the home told us that management was not as visible as it should be. The acting manager shared their time between the service they were registered for and Green Park. Communication was not clear between the acting manager and the staff team, which meant that updates to care and new information may be missed. This in turn could lead to people receiving inappropriate care.

Staff understood their roles and responsibilities but were aware that they did not always have time to fulfil them properly so that people had quality care. People and staff were not actively involved in developing the service. People were happy with the level of influence they had over their lives however there was insufficient evidence that they were consulted over the way the service was run.

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?

Inadequate

The service was not safe. People told us that they felt safe. However, there were sometimes insufficient staff to care for people safely. Also, shortfalls in communication had resulted in a serious injury to a person.

People were not always safe because there were a number of trip hazards caused by equipment, uneven floors and worn carpets. There were shortfalls in the control and prevention of infection which placed people at risk of harm.

People were protected by staff who were safely recruited.People were sure they received the right medicines, and these were handled safely, however, they did not always receive them at the right time.

Staff had received safeguarding training and understood how to act if they suspected abuse.

Is the service effective?

Inadequate

The service was not effective. Staff were trained and supported to meet people's needs. However, the acting manager and provider did not support them to develop professionally and did not provide regular or effective supervision.

People had access to healthcare services when they needed them.

The acting manager and provider were aware of the principles of the Mental Capacity Act 2005 and how to make an application to request authorisation for a person's deprivation of liberty. However, people had not received mental capacity assessments when needed.

People were not sufficiently consulted about their meals however their nutritional needs were met and they had access to food and drink.

Is the service caring?

Requires Improvement

The service was sometimes caring.

Some staff had positive relationships with people and were reassuring and kind in their approach. However, staff were often rushed and did not always give people the time or attention they needed.

People were not involved in decisions about their care as much as they could be.

People told us that they were treated with respect and regard for their privacy and dignity. We found however that some care practice did not respect privacy or dignity.

Is the service responsive?

Requires Improvement

The service was not responsive to people's needs.

Summary of findings

Care plans contained detailed clinical guidance however they did not include people's individual social or spiritual needs and were therefore not personalised.

There was insufficient evidence that care had been discussed and planned with people. People's needs were usually met but their preferences were not sufficiently understood.

People did not have sufficient stimulation or interest in their lives.

People's concerns and complaint were listened to and usually acted upon.

Is the service well-led?

Inadequate

The service was not well led. There was no registered manager in place. Management was provided by the registered manager of another home who had no clinical qualifications. Nurses felt they lacked clinical support.

There were shortfalls in communication and leadership was not strong or visible.

The culture was not always supportive of people who lived at the home or of staff, and people were not sufficiently consulted or surveyed for their views.

Staff understood their roles and responsibilities but felt that they lacked the support they needed to improve people's care. They did not have regular meetings or sufficient opportunity to consult with the acting manager.

The acting manager had made statutory notifications to the Care Quality Commission where appropriate.

The quality assurance system was incomplete. There were gaps in checks and safeguards in the home which placed people at risk of harm and there was little emphasis on improvement.

Green Park 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 inspection took place on 14 January 2015 and was unannounced. It was carried out by one adult social care inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

After the inspection we requested and received a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We included information from the PIR in this report.

On the day of the inspection we spoke with five people who lived at the home, three visitors, the provider, the acting manager, and five members of staff including the acting manager, a nurse and three members of care staff. After the inspection we spoke with two health and social care professionals about the service and an environmental health officer.

We spent time observing the interaction between people who lived at the home and staff.

We looked at some areas of the home, including some bedrooms (with people's permission where this was possible) and communal areas. We also spent time looking at records, which included the care records for eleven people. We looked at the recruitment, supervision and appraisal records of three members of staff, a full staff training matrix, rotas for the past two months, eleven care plans with associated documentation, a number of audits and policies and procedures.

Is the service safe?

Our findings

The service was not safe. We examined a sample of two month's rotas. One month showed that there were always three care workers on each day shift with a nurse to care for 23 people. In addition there were ancillary staff such as a cook, a cleaner and a maintenance person. Two members of staff were on duty each night. The provider told us in the PIR that this was the staffing level the service aimed to achieve for this number and dependency of people.

The manager told us that staff were placed on duty with regard to their experience and skill mix. However, another month's rotas showed that there were only two members of staff on duty during the day on most days with a nurse and that on a number of days each week there was no cleaner available. We asked what plans were in place to cover for sickness and holidays. The manager told us that they worked a care shift when necessary and that existing staff would be asked to work extra hours. They did not use agency staff.

Staff told us that they often had to manage with two members of staff and a nurse to care for 23 people and that the level of staffing on the fully staffed rotas were not in reality often achieved. They did not feel that the level of staffing was always sufficient to care for people safely. For example, one member of staff told us that one person had not always been cared for according to their care plan for managing pressure areas. The care plan had stated that the person should have been repositioned every two hours and that this had not happened all the time because staff were too busy. Also, that a person had been nursed in the lounge all day when the care plan stated that they should spend some time lying in bed during the afternoon. They told us this was because there were insufficient staff to assist the person to bed. They also told us that the home was sometimes without a cleaner and that when this happened care staff would carry out cleaning duties which took them away from their caring role. This meant that there was the risk that people were not cared for safely. Staff told us that ancillary staff were sometimes asked to sit in the lounge with people, and that although these staff had received the same training as care staff they did not always have the experience to deal with people's behaviour in a positive or enabling way.

We received a concern from a health care professional that training had been cancelled more than once due to there being insufficient staff on duty. They reported that when they visited staff were rushed and finding it difficult to meet people's needs.

We found that the registered person had not protected people against the risks associated with insufficient staffing. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe. One person said, "Yes, (there is) always someone around". Another person told us, "Yes, I can lock my door." A visitor told us, "There are always staff around". However, one person told us that they had waited a long time for staff to help when their relative had needed urgent help with personal care and another person told us that sometimes their relative had not received the timely attention to continence care that they needed. They felt this was because there were not sufficient staff.

We spoke with one visitor who told us that their relative had been subject to an injury caused by another person living at the home. They felt that staff had not acted in a timely way to minimise the risk of this happening and believed the injury could have been prevented. They told us that following this the home had dealt with the issue effectively and that they now had confidence that their relative was safe. Staff told us that they may not always hear call bells if they were in the basement which was where a lounge was located. This may mean that people did not receive care when they needed it. We spoke with one visitor who told us that their loved one did not always have their medicines administered at the correct time and this was sometimes an hour late.

When people acted in a way which could be challenging to others, staff responded in a positive manner. They spoke with people in a respectful way which acknowledged their distress and they kept people safe from harm.

We found that communication between staff and management before a recent untoward incident had not been sufficient. The result of the local authority investigation into this incident found that increased monitoring should have been put in place prior to the incident and may have helped to avoid the serious injury

Is the service safe?

which occurred to one person who lived at the home. Also, it was found that night staff had not kept movement sensors with them which would have alerted them to a person leaving their room. However, since this, the acting manager had carried out the correct action to safeguard people and the risk of a similar future incident had been minimised. The provider told us in the PIR that this incident had led to the introduction of signing sheets to ensure that movement sensors were carried by staff at all times.

Staff application forms recorded the applicant's employment history, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to commencing work at the home and that employment references had also been received. This provided evidence that only people considered to be suitable to work with vulnerable people had been employed.

The acting manager kept records of lift servicing and we saw a recently issued five year electrical safety certificate. Regular checks were made of the fire fighting equipment, portable appliances, water temperatures and emergency lighting. Accidents and incidents were also recorded. We saw that there was a hoist on each floor with slings and slide sheets for safe moving and handling. We observed that care staff used safe techniques when using this equipment.

We were not able to see risk assessments for the environment as the acting manager could not locate these and told us they were not up to date. The acting manager told us that they walked around the building regularly and made a mental note of jobs which needed to be done. There was no written record of these checks. During our time in the home we saw items stored in an upstairs stairway which blocked the staircase. While staff told us that people who lived at the home did not access this staircase it caused an obstruction to staff. We also saw that an unused hoist was stored in one person's room. Some floor areas in the home were uneven and could cause a person to trip. The electronic door holders could also potentially cause harm if tripped over when the door was closed and some of the trunking used in some rooms to cover electric wiring may also prove hazardous when the bedroom door was closed.

Individual risk assessments for people's care were detailed and covered how risks would be minimised, but they included insufficient detail of how to maximise freedom. For example, the acting manager told us that the risks associated with the use of stairs was managed by ensuring that people always used the lift and that staff accompanied people wherever they walked within the home. This restricted people's movement around the home. There was no record of how people or their advocates had been consulted over managing risk.

Staff had safeguarding training in place which was regularly updated. We saw that certificates had not yet arrived for the latest training, however, staff told us that they understood what constituted abuse, and who to report this to.

The provider told us in the PIR that the acting manager had initiated safeguarding alerts where this had been necessary and had fully co-operated in safeguarding processes. Daily contact was maintained with members of the North Yorkshire County Council Adult Services team and close contacts have been developed with the Mental Health team of Scarborough and Ryedale Care Commissioning Group. The service had a whistle blowing policy and procedure and staff understood what they should do if they wished to raise a concern in this way.

Staff understood the principles of good infection control practice, they spoke about the use of aprons and gloves and what to do to prevent cross contamination. We saw that the service had an infection control policy and procedure and that staff had received up to date training in infection control which meant people could be protected. The provider told us in the PIR that liquid soap and paper towels were used throughout the building and that visitors were encouraged to apply anti-bacterial hand wash before entering the building. We saw this was the case on our inspection.

We spoke with an environmental health officer who had visited the home in December 2014. They had found a number of shortfalls in cleanliness and infection control and had issued a notice for the home to attend to urgent repairs in the kitchen within a seven day timescale. They also issued a food hygiene score of 1, the lowest score possible. Since this time the environmental health officer had returned to the home and had found that the first action had been completed. However, they issued a further requirement regarding the kitchen flooring which had a timescale of the end of March 2015 for completion. The acting manager was not proactive in their management of infection control which meant people were placed at risk.

Is the service safe?

The service had a medicines policy and procedure. We observed a nurse administering morning medicines. Protocol and good practice guidelines were followed despite the difficulties of taking the medicines to different floors. All Medicines Administration Records (MAR) charts were signed correctly and the trolleys were clean, stocked correctly and locked to the wall. The treatment room fridge was clean and stocked correctly with an integral thermometer to record temperatures. Fridge temperature records were mostly completed, however, six had been missed in January which meant that the staff could not be sure that medicines in the fridge on those days had been stored at the correct temperature. Cupboards were well stocked and labelled in sections for each resident. Creams were all in date and labelled.

We noted that there was information from the pharmacy that staff could refer to and that telephone numbers were clearly in view to contact for queries, orders or emergency supplies.

Ten people did not have a photograph on their administration record. This could potentially lead to errors in administration.

Four people had hand written entries on the MAR sheet which didn't have two full signatures which is best practice when medicines are added in this way. This is to ensure that the correct drug and the correct dosage is given and may have led to an administration error.

A nurse told us that the medicine round took between two and three hours because of the lay out of the building, this meant they were not available for other tasks or to support care workers as much as they needed to. It might also mean that people did not get their medicines at the time they needed them. The provider told us in the PIR that they were to contact Boots to provide equipment to make it easier to transfer medication from the medication trolley to the person.

The acting manager told us that they did not carry out written medicine audits but that they regularly carried out informal checks. This meant that the acting manager did not have a clear oversight of medicine procedures and was therefore not in a position to recognise trends or identify required improvements.

We recommend that the provider refers to best practice guidelines on how to improve the control of infection in the home.

We recommend that the provider refers to best practice guidelines on how to ensure that the environment is free from hazards.

We recommend that the provider refers to best practice guidelines on assessing and managing risk to protect people while promoting their freedom.

Is the service effective?

Our findings

Staff told us that they rarely received supervision. We saw large gaps between the supervision records on five staff files. One member of staff told us, "Supervision is not regular and when it happens it is not that helpful. We have nobody to ask about clinical issues. We really need better support." Staff told us that they were not sufficiently supported to develop professionally in terms of specialist training or guidance about their career progression.

We found that the registered person had not protected people against the risks associated with inadequately supervised staff. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nine of the 11 people's care records we saw had no assessment of their mental capacity where we would have expected this due to their cognitive impairment. There was no recording of people's involvement in decisions about their care.

We found that the registered person had not protected people against the risk of insufficient involvement in decisions about their care or assessment of their mental capacity. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that sometimes people occasionally did not get assistance with fluids or repositioning as frequently as they needed because of time constraints. They told us that people sometimes did not receive assistance to return to bed from the lounge so that they could lie down because there was not time to move them to their bedrooms, though their care plans stated this was necessary. This meant that at times people were not having their needs met.

We found that the registered person had not protected people against the risks associated with hydration and pressure care. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt staff has sufficient training and skills to care for them. People felt they were able to make some choices about their day. For example one person told us "Yes, I have choice of where I have lunch" and "I choose when I get up and when I go to bed". One person told us the food was "Alright, no choice but I always like what they bring me, I don't like fishcakes, burgers and sausages and staff know this." Another person told us "Meals are absolutely gorgeous" and " I usually have a choice." Another person told us they had requested a couple of boiled eggs for tea one day but the staff had told them they could not have this.

Some people told us that health care professionals were called when needed. One person told us "Yes they would call a Doctor, I have (asked) and the Doctor comes quickly." However another person told us. "You have to plead to get a Doctor." We observed that one person had very long finger nails which posed a risk of the spread of infection, catching on clothing and causing injury.

The acting manager told us that staff had regular in house training in all mandatory areas, including the Mental Capacity Act 2005 (MCA) and dementia care. Some staff had also received training in areas such as diabetes care and end of life care. Computer records confirmed this, though we saw that some training was out of date.

Staff told us that they had an induction period where they shadowed more experienced staff and were introduced to the people living at the home and their care needs. They told us they continued to shadow until they were confident to work unsupervised. Staff had training records in all mandatory areas of care including dementia care. Some of this training was out of date which meant there was a risk that people would not benefit from staff trained in up to date best care practice.

When we spoke with staff they were knowledgeable about the needs of the people they supported and knew how these should be met, though from our observations people did not always have their needs met. One member of staff told us how they worked with one person who had behaviour which could challenge and how they minimised the risk of a situation escalating. Another member of staff

Is the service effective?

told us about their dementia care training and how it had helped them to understand why people acted in the way they did, what to do to reduce people's distress and improve their wellbeing. Staff told us that it was sometimes difficult to ensure that they all attended to mandatory training because they were not paid for this, and so had to carry this out in their own time. They also told us that because the training was online they missed out on discussions about their learning and the support of learning alongside colleagues.

There was a menu, however people did not appear to be reminded of menu choices when it came to lunch time, or assisted to make a decision about their preferences. The provider told us in the PIR that people's likes and dislikes were noted in their care plans and reported to the cooks and other relevant staff. The main meal looked appetising. One person told staff that they did not want the main meal choice and was asked if they preferred soup. The person agreed to vegetable soup. Staff brought them a bowl of soup which was clearly not vegetable. The person said to us, "It's chicken soup isn't it? They know I don't eat chicken." Staff brought this person a sandwich of their choice after this. This situation could have been avoided if staff had spent sufficient time with the person to understand what they would like to eat and to provide it.

Staff attended to people who needed assistance with their meal in a kind and discrete way. People took their meal in their rooms or ate in lounges. The dining room was not used for serving meals and items un-associated with meal times were stored there. People were not offered the choice to sit in the dining room and an opportunity for a social occasion was missed. Care plans included information about people's clinical care needs including nutritional needs with risk assessments where necessary. Nutrition and fluid intake charts were available where required and records of daily diet and fluid intake.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of MCA legislation which is designed to ensure that any decisions are made in people's best interests. The registered manager told us that a small number of applications had been made to the local authority for deprivation of liberty safeguards to be put in place, but that nobody had yet been assessed as being deprived of their liberty. We saw some records of Best Interests decisions which had been initiated by the Local Authority. Although DoLS applications had been made, there was no evidence on four of the five files of DoLS assessments. This meant that it was not possible to know how the assessment process had identified those people who should have DoLS applications. Despite this care staff were clear on the process for DoLS and mental capacity assessments as well as best interests decision making and the implications of lasting power of attorney powers.

Staff understood that people may have the capacity to make some decisions but not others. Though staff spoke about the need to assist people with their decision making through using pictorial aids and making sure that people were approached when they were at their most alert, none of these methods were recorded on individual files and we did not see any evidence of such methods being used during our inspection. This meant that people were not always supported to make decisions about their care.

Some care plans recorded how best to frame questions so that people could understand, and how to read individual body language and facial expressions.

GP and other specialist health professional visits were recorded in files. Staff understood about the specialist health care interventions people required and received. The home had links with specialists, for example in diabetic care, nutrition, sight and hearing, pressure care, continence care and the speech and language therapy team (SALT). This helped them to offer appropriate care. Staff told us that they accompanied people to health appointments so that they could support them and communicate health care information back to the home.

Positional changes, continence care, behavioural charts and other clinical records were kept up to date so that staff and health care professionals could assure themselves that people's clinical needs were being met. However as highlighted above, care workers told us that despite records being kept, people did not always receive the clinical care they needed.

Staff told us that there were sometimes difficulties with handing over information from one shift to another. One member of staff told us that "information is not always passed over at handover." This seemed to result from some staff not recording information accurately. One care worker told us, "A lot of updates are word of mouth so if you miss

Is the service effective?

something, then that's it, it isn't written anywhere." They told us that there was a communication book in place but that this was not always used effectively. This meant that people were at risk of not having their needs met.

We recommend that the provider consults best practice advice on ensuring people have choice around their meals and that those people who have cognitive or other difficulties are assisted to make choices through the use of suitable aids.

Is the service caring?

Our findings

People told us that the staff were caring in their approach. For example, one person told us, “They do care and check I am okay.” Another person told us “They tell me what's happening and they listen to me," and "I trust staff." Another told us “They say we are here to help you.” When asked about whether they were asked about choice in their care one person told us "I usually get a bath about once a week, I tell them when I want one and I get one." When we asked people about whether staff respected their privacy and dignity one person told us, “Yes, no problems”. A visitor told us, “Yes they always use a screen around the bed.” Visitors told us that they were consulted most of the time. They told us they were encouraged to visit at all reasonable times, and made to feel welcome.

Some staff spoke with everyone, including people who were either withdrawn or agitated, and responded kindly. We noted that one member of staff spoke discretely to a person who required assistance to visit the toilet which preserved their dignity. While assisting people with their lunch staff were on eye level with them. They reassured people with a touch on the arm or hand where this was appropriate. However, we also noted that there were times when staff were not available in a lounge and saw that one person asked for help and waited a long time for assistance. This led to them becoming distressed. Some staff did not interact with people very much and would assist them efficiently but without much warmth.

Staff told us that they understood people’s personal histories, their likes and dislikes. We observed that some staff did appear to know people’s preferences and social relationships. However, there was insufficient evidence of personal histories on file, and little was recorded about what was important to people, their likes or dislikes. This meant that there was not much information staff could refer to which might help them to have meaningful conversation with people about their lives.

We observed that staff did not always ask people for their views on their care or their preferences. When the meal was served, people were given a plate of food rather than being asked what they would like. However, later we did see staff asking whether people would like to look at a magazine or take a walk around the floor. Care reviews did not always include details of consultation with people or those who acted on their behalf. However Best Interests decision documentation did sometimes record people’s views about their care.

We recommend that the provider consults best practice advice on how to ensure people’s privacy and dignity is protected.

We recommend that the provider consults best practice advice on involving people in decisions around their care.

Is the service responsive?

Our findings

People's needs related to dementia care were not always clearly addressed, and there was little in the environment to support people with a dementia related illness. There was no signage, or prompts such as a large calendar, date or season reminders to help orientate people, nor were there objects of interest to stimulate their interest.

We found that the registered person had not protected people against the risks associated with an environment which was not sufficiently adapted to caring for people with a dementia related illness. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff involved them in the planning of their care. For example one person told us they were, "Always asked" and another, "They do ask me."

Some people told us that they had never had cause to complain, saying, "Never made a complaint, nothing to complain about." If they had cause to raise a concern people told us they felt confident that something would be done to put this right saying, "I feel they would" and, "They would definitely."

People told us that they felt they had choice and control over their care saying, "Yes totally, yes I have."

People told us there was not much opportunity to become involved in activities. Typical comments were, "Not bothered about activities, none offered" and, "No activities apart from dominoes." We asked visitors about whether they would feel confident raising a concern. One visitor told us, "I would go to the manager of the home." Another told us, "I have expressed concerns and was listened to" and, "They keep me informed of everything".

People told us they were encouraged to maintain social relationships with those who mattered to them and visitors told us they were always made welcome and involved in any celebrations such as birthday parties.

Staff showed a good understanding of people's care needs. One care worker told us "I know every person, what they did in the past and the people who are important to them." People's

care plans included details of the care people required. They included details on how to interpret people's body language, facial expressions and other indicators to understand how they were feeling and whether they agreed to care. One plan had a socialisation plan. However, plans overall had a clinical emphasis and there was insufficient information about people's lives, their interests or what was important to them to improve their well being. Other than people's involvement in Best Interest Decisions recorded by the local authority, care plans did not give sufficient details of consultation about decisions. Although people told us they did have choice and control over their lives there was limited written evidence of how this was promoted. The provider told us in the PIR that they planned to provide closer supervision for staff who completed care plans so that they could be more person centred. They told us that people were involved with their own care through ongoing interaction between the staff and with their families.

The home was arranged over a number of floors which made moving around without support difficult, though some people commented that this gave the service a homely feel.

We were told that one person had not had a bath for a long time as there was no suitable equipment to move them. The acting manager had not addressed this issue and the person had managed with body washes rather than having the option of a bath or shower. One visitor told us that staff did not have time to assist their relative to get out of bed and have a walk and that a physiotherapist had not been arranged for an assessment as requested.

People in the lounge were engaged in playing dominoes for some of the time with a member of staff, music played for a time and one carer gave two of the people a manicure. We also observed a member of staff spend time looking at a newspaper with a person. An activity plan was displayed on the notice board, but this was not a reflection of what was on offer as the activities planned for that day did not take place. The provider told us in the PIR that staff accompanied one person to the gym on a weekly basis. Staff told us they did their best to chat with people while they were giving care. There was a television on in the

Is the service responsive?

lounge for most of the day, which few people were watching. One person told us that staff would go with them into town or to a café, but that this didn't happen very often.

Staff told us that they regularly visited those people who spent most of their time in their rooms to check on them and have a chat to reduce the risk of isolation and loneliness. During our inspection we observed staff chatting with people in their rooms while they were carrying out personal care tasks, but we observed that staff were generally rushed in their work.

The activities record was not completed consistently, so that is was not always clear what people had done with their day. There was no member of staff who held responsibility for arranging activities and staff told us that some of the time people had little to do. A care worker told us that there was always a member of staff with people in the lounge but that they often needed to intervene when there was a problem and didn't always have time to engage people in stimulating activity. We observed one person who remained in a chair with nothing to do for six hours other than to eat lunch and visit the bathroom, although staff did talk with this person for short periods of time. We observed that for some of the day people appeared under-stimulated and bored.

Concerns and complaints were recorded and there was a supply of complaint forms in the reception area of the home. The investigation and outcome of each complaint was recorded with learning points for staff. The acting manager told us that people were consulted on an individual basis and that they and visitors raised any concerns on a day to day basis which were resolved straight away. Visitors we spoke with told us that they had sometimes raised concerns which had taken a time to address or which had not been addressed to their satisfaction. This meant that the way the service handled concerns and complaints was not always to people's satisfaction.

We recommend that the provider takes advice regarding the provision of personalised care which reflects people's lifestyle choices.

We recommend that the provider consults best practice advice on the provision of activities for people with cognitive and physical impairments to ensure people have meaningful things to do with their time which they enjoy.

Is the service well-led?

Our findings

The service did not have a registered manager. The acting manager was registered for another sister service and does not have clinical qualifications. Staff told us that they and the people they cared for were at a disadvantage because they did not have a registered manager who was dedicated to their home. They told us that because the acting manager did not have clinical expertise nurses had to rely on each other for support. Although the acting manager was in telephone contact with the home and often called in, staff told us this was very different to having someone on hand all day and that they tended to see the acting manager most when there was a problem.

The acting manager carried out some audits and checks. For example, lift servicing, fire checks, emergency lighting checks, moving and handling equipment servicing and irregular care plan updates. However, there were no written audits for medicines, infection control or environmental safety. This meant there was insufficient overview of the service and mistakes or omissions may be missed. As a result, people were at risk of harm. Updates and communication between shifts were almost all word of mouth which staff told us created a risk that things could be missed. The acting manager did not appear to appreciate that the lack of recording could have serious implications for people's safety and quality of life or to fully grasp the key challenges to improving the quality of care.

We found that the registered person had not protected people against the risks associated with insufficient assessment and monitoring of the service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they knew who the manager was. One person told us "I don't know her name." Another commented "I don't see management. " However, another person told us "Staff all know who is in charge." When asked if they could approach the manager or staff and get a positive response one person told us "Yes I think I could." Another told us "I don't think so." The provider told us in the PIR that the acting manager made a point every time she saw a relative to ask them how things were with the care of their relative and that relatives and residents were encouraged to come to the manager with any questions and concerns. Some people we spoke with told us their concerns were not always resolved to their satisfaction, although all told us they were approachable and ready to listen.

Staff told us that nurse's time was mainly taken up with administering medicines and making health related calls and referrals. Because of this they were not always available to give a clinical overview of care or to offer leadership and support to non clinical care workers. Staff told us there has been no staff meetings since last August and we could not locate any staff meeting minutes. They commented that the acting manager did not proactively seek their opinions. They told us that they had regularly fed back about the quality of equipment, that hoists were manual which did not have a smooth action and so were often uncomfortable for people when they were hoisted in them. They told us they felt there was a general lack of investment in the home. They told us that little was done as a result of their comments and feedback.

The acting manager told us that their priority was to ensure people were safe and that they didn't have time to plan improvements to people's quality of life. They acknowledged that the management arrangements were not suitable as they stood .Management was not proactive, but reacted to emergencies and to issues as they arose.

The acting manager had made statutory notifications to the Care Quality Commission where appropriate.

We spoke with the Provider about the concerns we found at the home during our visit. They told us they were committed to recruiting a manager for the service as soon as possible, but that recruitment had been difficult. They told us that recruiting nurses was also a priority and that they were finding difficulty in doing this also. The service has a history of changing management. This means that there has been inconsistent management for a number of years. Staff turnover was high.

We recommend that the provider consults best practice advice on strengthening the visibility and the quality of management, communication with staff and people who live at the service and others with an interest in their care.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person has not taken appropriate steps to ensure that people were protected against the risks associated with hydration and pressure care.** **The registered person had not protected people against the risks associated with an environment which was not sufficiently adapted to caring for people with a dementia related illness.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not taken appropriate steps ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health and welfare of people.** **People were not protected by staff that had suitable supervision, appraisal and support in their role.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People were not protected against the risks of inappropriate or unsafe care because the service was not effectively assessed and monitored.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	People were not protected because the provider did not have suitable arrangements in place to obtain and act in accordance with their consent to care and treatment.