New Century Care (Eastbourne) Limited

Tredegar Care Home

Inspection report

13 Upper Avenue
Eastbourne
East Sussex
BN21 3UY

Tel: 01323412808
Website: www.newcenturycare.co.uk

Date of inspection visit:
18 February 2016
19 February 2016

Date of publication:
17 May 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection at Tredegar Care Home on the 3, 4 and 9 March 2015 where we found improvements were required in relation to staffing numbers and staff training, respecting people and maintaining their dignity, consent, people's records did not accurately reflect the care they needed and there was not an effective system in place to assess and monitor the quality of service. The provider sent us an action plan and told us they would address these issues by July 2015. We undertook an inspection on 18 and 19 February 2016 to check that the provider had made improvements and to confirm that legal requirements had been met.

We found some improvements had been made however not all legal requirements had been met.

Tredegar Care Home provides nursing and personal care for up to 26 people. There were 23 people living at the home at the time of the inspection. They had a range of complex health care needs which included people who have a stroke, diabetes and Parkinson's disease. Some people had a degree of memory loss associated with their age and physical health conditions. Most people required help and support from two members of staff in relation to their mobility and personal care needs.

Accommodation is provided in single and double rooms and was spread over three floors with a passenger lift that provides level access to all parts of the home. People and visitors spoke well of the home and the staff.

There is a registered manager at the home. 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.

This was an unannounced inspection which meant the provider and staff did not know we were coming. It took place on 18 and 19 February 2016.

People's safety had been compromised in a number of areas. There were not enough staff on duty to safely meet people's needs. People's needs had not been taken into account when determining staffing levels. People's medicines were not always managed safely because there was no guidance in place for people who had been prescribed 'as required' medicines. Risks were not always safely managed. Although risk assessments and care plans were in place these did not contain all the guidance needed to support people. There was a current reliance on agency nurses at the home who did not know people, therefore clear guidance is essential.

Staff had an understanding of mental capacity and deprivations of liberty and appropriate authorisations were in place or applied for. However, there was no information about how staff should support people who lacked capacity.

People had a choice of meals and snacks throughout the day. However, mealtimes were disorganised and people did not receive support in a timely way.

Staff had not received all the training updates they needed for the provider to be sure they had the appropriate knowledge and skills to look after people. There was no clinical supervision in place for nurses.

Staff were kind and caring. The care staff knew people well and understood the care people needed and how they liked this delivered. However, due to constraints on staff time the care people received was task based and not person-centred.

The audit systems had not ensured that actions identified at the last inspection had been addressed. The systems to assess the quality of the service provided were not always effective. Action was not always taken when areas for improvement had been identified.

The registered manager was seen as open and approachable. People, visitors and staff told us they could discuss concerns with her at any time.

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

People were protected, as far as possible, by a safe recruitment system. Staff files had a completed application form, references and other appropriate employment checks. Nurses were all registered with the nursing midwifery council (NMC) which was up to date.

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. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we 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.

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

Tredegar Care Home was not consistently safe.

There were not enough staff to meet people's needs. People's needs were not taken into account when determining staffing levels.

Risks were not always safely managed. Individual risk assessments were in place however, these did not always contain the guidance needed to maintain people's health, safety and well-being.

People's medicines were not always managed safely. There was no guidance for 'as required' medicines.

Staff were recruited effectively and people were safeguarded against the risk of abuse.

Is the service effective?

Inadequate

Tredegar Care Home was not consistently effective.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and appropriate referrals had been made. However, there was no guidance about how this affected people on a day to day basis.

Although there was a training and supervision programme in place not all staff had received their mandatory training update. Nurses had not received clinical training updates and there was no clinical supervision in place.

Mealtimes were not consistently organised and did not provide a pleasurable eating experience for people. People did not always receive the support they required.

People were supported to have access to healthcare services this included the GP, dietician and chiropodist.

Is the service caring?

Requires Improvement

Tredegar Care Home was not consistently caring.

We observed occasions where people were not treated with the respect they deserved.

However, in general people were treated with kindness and compassion by staff who knew them well. We observed staff interact well with people. They were thoughtful and gave reassurance to the people they supported.

Staff maintained people's privacy and understood the importance of confidentiality.
.

Is the service responsive?

Requires Improvement

Tredegar Care Home was not consistently responsive.

Although people were able to make some choices the care they received was task based and not person-centred due to constraints on staff time.

People did not always receive the care they needed. Some people spent a considerable amount of time in the lounge without any interaction or stimulation from staff.

A complaints policy was in place and complaints were handled appropriately.

Is the service well-led?

Inadequate

Tredegar Care Home was not consistently well-led.

The provider's systems for audit had not ensured that identified actions from the last inspection had been addressed.

The systems to assess the quality of the service provided were not always effective. Action was not always taken when areas for improvement had been identified.

The registered manager was seen as open and approachable. People, visitors and staff told us they could discuss concerns with her at any time.

Tredegar Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection by three inspectors and an expert by experience. It took place on 18 and 19 February 2016.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and the provider's action plan. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with all the people who lived at Tredegar Care Home, we spoke with five visitors to get their view of the care provided. We observed the care which was delivered in communal areas to get a view of care and support provided across all areas. This included the lunchtime meals. As some people had difficulties in verbal communication the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us.

We looked around the home, including the bathrooms, sluice rooms and some people's bedrooms. We spoke with three agency nurse, one regular nurse, eight care workers, the cook, the maintenance man and the registered manager. The area manager was present for some of the time on the second day.

We reviewed a variety of documents which included six care plans and risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed the records of the home. These included information in regards to the upkeep of the premises, staff recruitment, training and supervision records, medicine records complaint records , accidents and incidents, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

At our last inspection in March 2015 the provider was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found there were not enough staff on duty to look after people safely. An action plan was submitted by the provider that detailed how they would meet the legal requirements by July 2015. At this inspection we found although improvements had been made further action is required to ensure there are consistently enough staff on duty.

People told us they felt safe living at the home. One person said, "I feel safe when I have someone with me." We received a mixed response about whether there was enough staff. One person told us, "I can ring my bell and they usually come quickly." Someone else said, "You ring the bell and if you are lucky they come at once." One visitor told us although staff were busy they thought there were enough. Another visitor said, "Staff are rushed, sometimes they need more." People told us they received medicines when they needed them. One person said, "They (staff) will offer paracetamol if you are in pain."

We found there were shortfalls which compromised people's safety and placed people at risk from unsafe care.

We were told the number of care staff had increased from four at our previous inspection to five on each day shift. There was one nurse, a cook and domestic support on duty each day. There were two care staff and one nurse at night. The registered manager worked each day during the week. However, we found the lack of leadership and deployment of staff had not ensured that people's needs were met. There was a current reliance on agency nurses and they were focussed on the clinical aspect of providing care. One agency nurse told us, "I try to keep an eye on what's happening on the floor but I do have to concentrate on what I'm doing." Although the registered manager was available for support there was no staff responsible for the day to day running of the care delivery each shift. One staff member said, "I try and remind others about the right way to support people but I don't really have that authority. We do need someone to lead each care shift."

There was a dependency assessment tool to establish how many staff were required to meet people's needs. At the time of the inspection although the assessed number of staff were provided, this was not sufficient to ensure that people's needs were consistently met in a timely way. Staff were busy throughout the inspection. On the first day of our inspection they attended to people in the lounge in a timely way and call bells were answered promptly. On the second day we observed staff were busier. We saw three people waited 15 minutes to be taken to the toilet and three people had not been offered the toilet or their position changed from 10.15am to 1.45pm. This increased the risk of skin breakdown through prolonged sitting in one position and not receiving regular continence care. These people were therefore at risk from pressure damage. At 12.30pm on the second day care staff were still assisting people to get up and this impacted on the support people received at lunchtime. Staff told us that 22 people required the support of two staff with their mobility needs. We saw people who required support and remained in their rooms received their meals after people who were in the lounge or more independent. However, on the second day of the inspection we observed people who had moved to the dining room for their lunch were left waiting for staff to attend to

them and help them return to the lounge or their bedrooms. Staff told us there was not enough staff to attend to people in a timely way especially when people chose to eat their lunch in the dining room. This meant some people ate food that was cool and others were at risk of choking because there were not enough staff to support and supervise them.

Staff told us the activities co-ordinator had been working on the first day of the inspection and was able to support staff with caring duties. On the first day of inspection we observed staff regularly entering the lounge and checking if people required any support. During the second day staff entered the lounge when they brought further people in however there was limited time for any chatting or interaction. The registered manager told us she believed this was due to staff deployment rather than staffing numbers. Staff told us the increase in care staff numbers had improved however they were still busy and had little time to spend with people if they were not providing direct care. One staff member said, "It's like today (the second day of the inspection) we don't have time to do activities with people we're too busy." This meant there were not sufficient staff deployed to meet peoples individual needs and was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us there were not enough nurses currently employed at the home and there was no clinical lead. Since our last inspection two clinical leads had been employed but they no longer worked at the home. There were four nurses who worked at night and one of these worked a few hours during the day each week. The registered manager told us they were currently recruiting nurses but in the meantime the vacancies were filled by agency nurses. We were told regular agency nurses were used as far as possible. We spoke with three agency nurses, two had worked at the home previously and had some understanding of people and their needs. They told us the induction was useful as it gave them an introduction to the home and an understanding of the daily routine. There was a checklist in place when agency staff worked at the home. This included an induction introduction to the home and a check to ensure they were registered as nurses and able to work at the home.

We observed medicines being given on both days of the inspection. The morning medicines were still being given at 11.30am. The agency nurses acknowledged they were slow but said they wanted to ensure medicines were given correctly to the correct people. This placed people at risk of not receiving their medicines at the prescribed time, which may be essential for particular types of medicine. There was a system in place to order, store and dispose of medicines safely. Medicine administration records were completed when medicines were given. We saw some people had been prescribed 'as required' (PRN) medicines. Although there was some guidance and protocols in place these were not complete and contained conflicting information. For example one person had been prescribed two different tablets for anxiety or if distressed. There was no guidance in place for when these should be given, what symptoms the person may display which may indicate they needed the medicine. There was a current reliance on agency nurses during the day and whilst they told us they would talk to the registered manager or care staff before giving this medication there was a risk people could receive medicines unnecessarily or be left distressed. A number of people were prescribed painkillers for example co-codamol which contains paracetamol. The PRN guidance informed staff not to give this medicine with paracetamol however it did not inform staff not to give paracetamol with co-codamol. Someone else was prescribed ibuprofen tablets and ibuprofen gel but there was no guidance about whether these could be given together. This meant people could be at risk of receiving more medicines than was safe. There was no information about why people required pain killers. When PRN medicine was given the reason for this had not been recorded.

Some people required skin creams. These were recorded on the medicine administration record MAR as applied by the care staff. Body maps were in place to show where and when people required cream to be applied. However, some people required more than one cream and whilst a number of body maps were in

place they did not detail which cream they applied to. Therefore staff could not be sure they were applying cream correctly. Cream charts had not been fully completed to show creams had been administered as prescribed. Staff told us they knew people well and understood which creams they needed to apply. However, there no guidance in place to ensure medicines were given consistently or were effective.

Some people required medicines where the dose varied dependant on the results of blood tests. However, the information about the correct dosage for each day was not clear. This meant people could be at risk of receiving the incorrect amount of medicine and leave them at risk of harm or injury.

There was information about people's risks in risk assessments and care plans however guidance was not always accurate or followed correctly. One person had been identified as at risk of falling. Guidance identified this person required an alarmed mat by their bed or chair to alert staff if they tried to stand unaided. This was in place by the person's chair on the first day of inspection but not on the second day. This meant the person was at risk of falling as staff would be unaware if they tried to walk unaided. Another person required their position changed every three hours to prevent the development of pressure sores. Room charts showed the person had been observed visually each hour but did not record their position or if they had been moved. The provider could not ensure this person was receiving the appropriate care needed to maintain their health and safety.

Care plans for a further person informed staff the person needed support with meals due to swallowing problems. The care plan informed staff to refer to guidance from the speech and language therapist (SALT). This was stored in the kitchen and not easily accessible to staff. The guidance stated the person required a "pre-mashable diet" where lumps were mashed with a fork and mince was pureed. There was guidance about supporting the person which included the use of a teaspoon to ensure they didn't eat too fast and required supervision when eating. We observed this person eating a ham sandwich and later a meal which included ham. Whilst the food was cut into small pieces it was not of the consistency stated. They were not supervised whilst eating their sandwich. Staff told us this person was able to eat normal food as long as it was cut into small pieces. Their care plan for medicines stated they had no swallowing difficulties and were able to take their tablets one at a time. There was no information to say who had made the decision this person no longer required a pre-mashable diet. This left the person at risk of choking because safe guidelines had not been followed.

Some people had fluid charts in place if they had been identified at risk of dehydration. One staff member told us, "We check if they've had 200mls in the hour and if the cup is empty and try to give them drinks." One person's care plan stated they needed to drink one and a half to two litres of fluid a day. However, this person did not have a fluid chart in place to monitor their intake so staff would not know if this person was drinking enough. This left them at risk of dehydration.

There were nutritional assessments in place and people were weighed regularly. We identified one person had lost eight kilograms between June 2015 and February 2016. There was no evidence of any action having been taken to address this. This left this person at risk of malnutrition.

There were assessments in people's care plans about whether they could use call bells. We observed a number of call bells hanging up by the door. Later, we saw some people had been provided with call bells. One visitor told us their relative did not use a call bell but was able to call staff. It was not clear how other people who were unable to use a call bell would be able to contact staff. One person's care plan showed they understood how to use a call bell but may forget to do so. This person did not have access to a call bell. This left people at risk of not having their needs met as they were unable to contact staff when they needed them.

Some people had complex health needs and required clinical support from nurses for example in relation to managing their diabetes and catheters. However, there was no clear guidance in place for staff to follow to ensure people were supported safely. One person who was living with diabetes did not have a diabetes care plan in place. There was a medicine care plan but this did not include the current amount of insulin the person required but a dietary care plan informed staff of the diet this person ate. There was no information about the normal range of blood sugars for this person or what actions staff should take if they were not within this range. This meant people were at risk from uninformed staff.

Another person had a catheter. There was information in the catheter log about when the catheter had been changed but there was no information in the care plan in place to guide staff about the size and type of catheter, how often it should be changed or what staff should do if the catheter was not draining. There was a current reliance on agency nurses at the home who did not always know people fully. This lack of written guidance left people at risk of poor health or harm by not receiving the care needed or receiving care that was not consistent. We spoke with the agency nurses about how they would look after people. They told us where they would obtain information for example from the other staff, catheter logs, MAR charts and their own clinical knowledge.

Care plans were not always clear and did not demonstrate how decisions had been made when care needs changed. One person's care plan showed they had previously been supported to move by the use of a full body hoist and a more recent care plan stated they were using a stand-aid hoist. For people to use a stand-aid hoist they must be able to weight bear. The care plan stated the person was unable to weight bear but a moving and handling assessment had been amended in January 2016 and stated they were able to weight bear. The moving assessment had not identified this person was prone to periods of confusion which may impact on their ability to follow instructions when standing. It was not clear from their care plan how the decision had been made to use a standing hoist.

We observed a person being supported to move from a wheelchair to armchair with the support of a standing hoisting. Rather than supporting the person to a standing position the manoeuvre was seen to 'pull' the person upright putting pressure under their arms. The person had difficulty in weight-bearing and following instructions. This was not a safe or pleasant experience for them and placed them at risk from possible injury. However, we did also see people moved with skill and expertise and so the skills in moving and handling people were varied.

We identified areas around the home which could be hazardous to people. There were pipes in the ground floor bathroom and in a communal corridor on the ground and first floor. These were hot to touch and uncovered which could potentially burn people if they touched them. This was identified to maintenance staff who started work to rectify during the inspection. There was work being undertaken to the heating system. We saw portable heaters were in place in people's bedrooms. The registered manager told us these were temperature controlled and would not be hazardous to people if they touched them. However, they were a potential trip hazard to staff and there were no risk assessments in place to inform staff or mitigate risks. In one bedroom there was an area on a bedroom wall that was damaged. The area was open and plaster was crumbling. This was next to the person's bed, the plaster was accessible and could cause damage to a person's skin if they rubbed against it. The registered manager told us she was aware of this, however no steps had been taken to make the area safe before a proper repair could be completed.

Some people had wounds. Although there were tissue viability and wound assessments with photographs of wound at various stages of healing and measurements we were unable to locate wound care plans. The registered manager told us these had been completed for most people, she showed us information to demonstrate which had been completed. However, she was unable to locate these at the inspection. She

told us they may have accidently been archived. We spoke with the registered manager following the inspection and she told us wound care plans for people who required them had been re-written and were in place in people's files.

The risks to individuals' safety and welfare had not been fully assessed and managed effectively and are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were health and safety checks in place and these included water temperature and fire safety checks. We saw staff had received fire safety training. There was regular servicing for gas, electrical installations the passenger lift and hoists. There were detailed personal evacuation and emergency plans in place for everybody. The home was staffed 24 hours a day with an on-call system for management support and guidance.

Staff recruitment checks were undertaken before staff began work at the home. This helped to ensure, as far as possible, only suitable people were employed. This included an application form with employment history, references and the completion of a Disclosure and Barring Service (DBS) check to help ensure staff were safe to work with adults. Nursing and Midwifery Council PIN checks for registered nurses had been recorded and demonstrated they had the appropriate qualifications for their job.

Staff told us they had received safeguarding training and understood their responsibilities in relation to safeguarding people in order to protect them from the risk of abuse. They told us what actions they would take if they believed someone was at risk and how they would report their concerns. Staff told us if appropriate they would report to the registered manager and were confident the appropriate actions would be taken. Staff had an understanding of their duty to inform external agencies such as the local authority. There was a safeguarding policy in place which was currently being reviewed by the provider.

Inadequate

Is the service effective?

Our findings

At our last inspection in March 2015 the provider 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. Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. The provider was also in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities). Staff had not received appropriate training, professional development and supervision. An action plan was submitted by the provider that detailed how they would meet the legal requirements by July 2015.

At this inspection we found although the provider was now acting in accordance with the legal requirements where people did not have the capacity to consent, further improvements were required. Staff received ongoing training and supervision, however there was no clinical supervision in place for the nurses and no competency assessments had taken place.

People told us they were well looked after and were able to see their doctor when they needed to. One visitor told us their relative was "well cared for." There was mixed feedback from people about the food. People told us they had choices and had enough to eat. Some told us the quality of the food was good and it was well presented. Others told us the food could be better.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had submitted DoLS applications to the Local Authority for people who did not have capacity and were under constant supervision by staff.

There was a copy of the DoLS application and mental capacity assessment in people's care plans. However, there was no mental capacity care plans or information in other care plans about how restrictions may affect people and what had been done to minimise restrictions. Some people had bed rails in place. Although people and their representatives were involved in the decision there was no rationale or evidence of any discussion having taken place to determine this was in the person's best interest or whether less restrictive practices had been considered. Some people shared bedrooms and there was no evidence of how this decision had been made. The registered manager told us this was discussed with people and their relatives when they moved into the home. There was no evidence of meetings taking place to ensure sharing a room was in people's best interests. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nurses had received some clinical training, however not all nurses had received recent training. From the seven nurses employed at the home, which included bank nurses, four had not received diabetes training and three had not received catheter and continence training. There was no clinical lead nurse in post at the home and at the time of the inspection nurses did not receive clinical supervision. No assessment of clinical competencies had taken place. This meant people were at risk of receiving care from nurses who did not have the appropriate knowledge and skills because the provider had not ensured appropriate training and supervision was in place. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a training and supervision programme in place. The registered manager told us she was aware staff training and updates were required and this was being monitored by the provider as it had been identified not all staff had received the training and updates required. Staff told us, "We get a lot of training." This was provided face to face and via e-learning. Overall 67% of staff were current with their essential training however this contained variances. For example 89% of staff had received practical moving and handling training, 29% had received safeguarding training. We saw future training had been booked. Where training needs were identified appropriate training was given to inform staff and update their knowledge and skills. For example staff had received recent training in relation to maintaining people's continence. We saw staff who had been identified as requiring an update to their knowledge and skills had received their training first. There was an ongoing programme of supervision. Records showed and staff told us supervision was one to one and group. It included reminders of good practice for example in relation to the correct use of continence products. This had been in response to concerns identified. Supervision was recorded and signed by staff. Staff also documented they understood the information they received and how it would help them in their day to day practice.

There was an induction programme when staff started work at the home. This included the day to day running of the home, policies and people's care records. Staff then spent time shadowing other staff before they worked unsupervised. Staff told us their induction provided them with
the knowledge and skills to look after people. They said they were well supported by the registered manager and their colleagues and could always approach them for help. Agency nurses told us and records confirmed they received an induction the first time at the home to introduce them to people, the daily workings and routine.

We observed lunchtimes on both days of the inspection. We had been told of changes at mealtimes where people who both remained in their rooms and required assistance were supported after people who remained in communal areas or were independent. People were offered a choice of where they would like to eat their meal and this was respected. On the first day people chose to remain in their rooms or the lounge and people were supported appropriately. On the second day some people chose to eat in the dining room. The lunchtime for people on the second day was chaotic and did not provide a pleasant dining experience for people. We observed people in the dining room and saw they were left unattended which meant two people who required prompting did not eat their meals. People in the lounge received assistance but we observed staff left people to attend to others. One staff member said, "I know we shouldn't interrupt people's meals but I can't not attend to others if they call." However, this interruption meant people were served food that was lukewarm. Despite people being offered choices at mealtimes we observed hot drinks being served mid-morning on the second day and people were not offered a choice of hot drink by the staff member and were all served tea. This meant people's individual choices and preferences were not taken

into account.

On the second day of the inspection we observed an unusual food combination at lunchtime. Ham, egg and chips was served with mushy peas, carrots and swede. This not look appetising and people told us they found the combination 'strange'. People's individual nutritional and hydration needs were not consistently met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We did see evidence of good practice in relation to people's nutrition. Staff had a good understanding of people's religious and dietary preferences. There were dietary profiles in people's care plans with a copy in the kitchen. These were placed on people's meal trays as guidance for staff. They included information about people's dietary needs for example a diabetic diet, their likes and dislikes. People were offered a choice of meals and if they did not like what was on offer alternatives were offered. We observed one person had declined their meal and staff offered them alternatives. One staff member told us, "We change the menu for them if they don't want what is on offer; we go back to the kitchen, sometimes want soup or something else". There was a selection of snacks in the lounge and available for people to eat. Staff told us about one person who liked to 'graze' throughout the day. We saw they enjoyed a variety of snacks throughout the day.

People were supported to have access to healthcare services and maintain good health. We saw from their care plans they had were referred to their GP, dietician, speech and language therapist as required. People told us they were able to see their doctor whenever they needed to. One person told us, "If I need it, they will call the GP for me." We saw from people's care plans they had regular access to the dentist, optician and chiropodist. One visitor told us their relative had regular access to a chiropodist.

Requires Improvement

Is the service caring?

Our findings

At our last inspection 3, 4 and 9 March 2015 the provider was in breach of breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. An action plan was submitted by the provider that detailed how they would meet the legal requirements by July 2015. At this inspection we found improvements had been made however further action is required to ensure people's dignity is always maintained.

People told us staff were kind and caring. One person said, "Staff are caring, they're my friends." Another person told us, "They do listen to me." A visitor told us, "Staff are brilliant, they really care." However, another person told us the impact of not enough staff affected them. They said, "I want to go to bed but they don't come."

We observed two incidents where people were not treated with the respect they deserved. We saw a staff member mopping a person's bedroom floor whilst they were eating lunch and hoovering the lounge whilst another person was eating breakfast. Another staff member 'nudged' people to gain their attention whilst asking them if they would like a cup of tea. We raised these concerns with the registered manager as areas that need to be addressed and improved.

Staff were busy and not able to spend as much time as they wished with people which left people isolated for long periods of time throughout the day. However, we observed staff worked at people's own pace. They did not hurry people and were patient. We observed staff talking with people as they undertook care. One staff member told us most "one to one chatting" took place when they provided personal care for people. We heard one staff member providing a meal for a person who remained in their bedroom. The staff member asked the person if they were alright, they told them about the meal and asked if they would like it cut up. Before they left the room they asked the person if everything was how they liked it. In addition to the task the staff member was also chatting to the person throughout the time they were in the room. We observed similar practice when staff were attending to another person who was less able to communicate verbally.

Staff knew people well they were able to tell us about people's individual life histories, their likes and dislikes and how they liked their care provided. One staff member told us they liked to know about people's lives before they moved into the home. They said, "It helps me look after the person now." We heard staff talking with people about their families and interests. However, we observed photographs in one person's room which showed them and a family member receiving an award. We asked staff but they did not know about this.

People were treated with kindness and compassion by staff who cared about the people they were looking after. We observed staff assisting people into chairs. They ensured people were comfortable for example readjusting one person's cardigan to ensure it was not twisted. We saw staff did not leave people until they were satisfied the person was comfortable. A visitor told us their relative was treated with respect. They said,

"I know this by observing the carers tone of voice and attitude and they show warmth and understanding." Staff told us they enjoyed their work. One said, "I love working with older people, I give my heart to this job."

Staff maintained people's privacy and understood the importance of confidentiality. We observed them knocking on people's doors before they entered. One staff member said, "We don't talk to people about other residents in front of people." Another staff member told us that treating people with respect gave people confidence.

People's bedrooms were personalised, where possible, with their own belongings such as photographs and other memorabilia. We saw people were dressed in clothes of their own choices. There was information in people's care plans about how they liked to dress. For example one person's care plan stated they liked to "well-groomed and dignified." We saw this person was dressed and presented accordingly. Staff understood the importance of ensuring people were clean and well presented. One staff member told us they had spent time ironing people's clothes. They told us, "I like people to look well cared for."

Requires Improvement

Is the service responsive?

Our findings

Visitors told us they were kept informed about changes in their relatives care and support needs. One visitor said, "They are quick to contact me if anything is wrong." Another visitor told us their relative "Can make his own choices and decisions." However, we did not find the service consistently responsive.

Pre-assessments took place before people moved into the home. People and where appropriate their representatives were involved in developing their care plans. They included people's views and reflected their individual choices and preferences about the way they wanted their care delivered. Although staff offered people choices throughout the day for example in relation to where they wanted to spend their day, what they wanted to eat or what they wanted to wear, the care they received was not person-centred but task based. This was because of the constraints on staff time. Staff assisted people to get up but this was dependant on their availability not on people's individual choices. People did not always receive the care they needed. We observed people who spent time in the lounge spent a considerable amount of time on the second day without staff being present. We sat in the lounge for 40 minutes and did not see a member of staff.

People's continence needs were not always managed effectively. Care plans identified when a person was incontinent, but there was no consistent guidance for staff in promoting continence such as taking people to the toilet on waking or prompting then to use the bathroom throughout the day. People were reliant on staff to support them with their mobility needs. On the second day six people remained in the lounge from 10am to 1.30pm without being offered a change of position or if they needed to use the toilet. After lunch three people asked to use the toilet at the same time which meant people had to wait and were not supported when they needed it. People's continence needs can be managed by regular prompting and responding to body language and timings for drinks and meals. Staff told us because they knew people well they tried to anticipate their needs and take them to the toilet regularly. However, this had not happened.

Care plans did not provide consistent guidance for staff. Whilst some were detailed others were not clearly written. For example one in relation to catheter care was four pages long and it would be easy for staff to miss Key points. Another catheter care plan informed staff to provide 'catheter care' but did not define what this was. Daily notes were completed by the nurses and included a brief overview of people's day but did not capture everything people had done, their mood or how they felt.

Care plans did not show when people's needs had changed for example in relation to their mobility, nutrition, medicines and clinical needs. One person was able to communicate verbally but this took time and did not instigate conversation themselves. This was not reflected in their care plan and there was no evidence any discussion had taken place to identify if this was the way they had always communicated, whether it was a result of illness or if for example they were depressed. Another person's care plan did not reflect the way their episodes of confusion may affect them for example with their mobility or making choices.

Staff completed hourly room checks for people. These included a visual check of where people were, if they

were in pain and their pressure areas. Although these records were completed we did not observe staff asking people each hour if they were comfortable. Pressure area checks were completed however it was not clear which pressure areas had been checked. Therefore staff could not be sure people's needs were met.

On the second day of the inspection the activities co-ordinator was not working. She told us she had a programme for the staff to follow in her absence. However, staff were busy and did not have time to deliver this programme. As a result people spent their day unoccupied and their social needs were not met. One person told us they were "bored" another person said, "Sometimes I feel I have wasted the day I used to be so active." There was some information about peoples past interests and hobbies and there was an activity programme in place. However there was limited information about how staff could support people to continue with their interests. The activities co-ordinator was new in post and told us this role was developing. She also told us currently people who remained in their rooms had limited opportunity for one to one activities, however this was an issue she was working to address.

People did not always receive the care they wished for or required. Care was task based rather than responsive to individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these concerns we did observe some personalised care being provided and work was in place to develop the activities. On the first day of the inspection we observed activities taking place in the lounge. The activities co-ordinator brought in an unusual fruit and shared it with people. This interested people and stimulated discussions. In the afternoon the gardener was invited to talk with people. This included a planting up session and the gardener potted up bulbs for flowers with one pot per person's room. Although people enjoyed this there were missed opportunities to engage people in filling the pots and discussing gardening. For example two people said they were gardeners and enjoyed gardening, they were not encouraged to plant their own bulbs, touch the soil or contribute in any way. Later, the cook joined the session and stimulated people's interest by suggesting several ways they could be involved in gardening such as planting up tomatoes in hanging baskets and having a tallest sunflower competition. This was greeted well by the people.

Staff understood the need for personalised care and told us how they supported people to make choices. They told us how they supported people to make choices about where they spent their day and how they would encourage them to come to the lounge when activities were taking place. A visitor told us their relative was able to make their own choices and decisions.

People told us if they would discuss any concerns or complaints they had with the registered manager or other staff. We saw a recent complaint had been addressed and there was a record of the actions taken to resolve the issues. The complaints policy was on display at the home and there were copies in people's bedrooms.

Inadequate

Is the service well-led?

Our findings

At our last inspection in March 2015 the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance and accurate records were not in place. An action plan was submitted by the provider that detailed how they would meet the legal requirements by July 2015. At this inspection we found improvements were still required in relation to this regulation.

The registered manager had a good overview of the home and areas where improvements were required. There was an action plan from the provider which she was working to address. However, some areas had been identified as needing improvement but no action had been taken. The registered manager was not a nurse and there was a lack of a clinical lead to support the nurses for example in relation to their clinical supervision and competency. Although this had been identified and a suitable clinical lead was being recruited the provider had not ensured appropriate clinical support was in place in the meantime. The nurses were responsible for ensuring care plans contained appropriate clinical guidance however these were not in place which demonstrated clinical supervision was essential.

There had been two clinical leads in post during the past six months and this post was currently vacant. There was a high turnover of nurses with a current reliance on agency nurses. Due to the lack of regular nurses care staff were not adequately supervised and there was a lack of guidance on floor. We observed an incident of poor moving and handling and people not receiving appropriate support at mealtimes. We highlighted this to the registered manager to be addressed. The registered manager undertook regular walks around the home and areas for concern such as poor moving and handling practices were addressed at the time and through supervision. However, there was no oversight on a day to day basis to identify if these issues had been addressed successfully or were on-going.

Quality assurance systems had not identified all the shortfalls we found. They had not identified that people's safety was potentially at risk from inadequate staffing levels that impacted on care delivery and raised potential risks to people's safety. There was a dependency tool in use but there was no evidence staffing levels changed in relation to people's needs.

Some care plans were lacking in clinical guidance in relation to diabetes, nutrition and continence that had the potential to cause harm to people. There was no mental capacity or deprivation of liberty guidance within people's care plans about how people who lacked capacity were able to make decisions. The PRN guidance did not contain all the information required to ensure the safe administration of medicines. There was no information about why people required pain killers. When PRN medicine was given the reason for this had not been recorded.

We identified throughout the inspection that many people spent time being unstimulated and socially isolated. Daily notes did not reflect the care and support people received. We found that staff did not have time to engage with people due to time constraints. We also found that people's nutritional needs were not

being managed effectively or monitored to ensure that people had enough to eat and drink. The environmental checks had not identified or addressed areas which had the potential to cause people harm.

The quality assurance framework was ineffective because the provider failed to have effective systems and processes to ensure they were able, at all times, to meet requirements in other parts of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and was a continued breach of breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were regular resident and staff meetings and the registered manager had introduced a monthly newsletter to keep people updated about what was happening at the home. The registered manager worked at the home on a daily basis. She was visible to people, staff and visitors and was well thought of. She was passionate about creating a positive culture at the home and had a clear vision for the future of the home. She took an active role within the running of the home and had good knowledge of the staff and the people. When issues arose, for example, poor care, we saw this was addressed through supervision and where appropriate disciplinary action. One agency nurse told us, "The manager is spot on, she's well respected and will always help."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 provider had not ensured that people received person centred care that reflected their individual needs and preferences. Regulation 9 (1) (a) (b) (c) 3 (a) (h) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. Regulation 11(1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. 12 (1) (a) (b)(c)(d) (g)

The enforcement action we took:

Warning notice

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 Accurate records were not in place in relation to the care and treatment for all service users. The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place. 17 (1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

Warning notice

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 provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Staff had not received the support, training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform. 18 (1) (2) (a

The enforcement action we took:

Warning notice