Culpeper Care Limited

Willow Tree Nursing Home

Inspection report

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Date of inspection visit:
01 March 2016
02 March 2016

Date of publication:
13 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 1 and 2 March 2016. The visit was unannounced on 1 March 2016 and we informed the provider we would return on 2 March 2016.

Willow Tree Nursing Home provides accommodation, personal care and support and nursing care to up to 47 older people. The home is divided into two units; Cedar unit provides accommodation for people living with health care conditions who are physically frail due to older age, and Oak unit for people living with dementia. At the time of the inspection 39 people lived at the home.

The home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. There was a registered manager in post.

The Local Government Ombudsman (LGO) had informed us, in November 2015 that the provider was required to submit an action plan outlining their plans to make improvement to care records at the home. The LGO investigates complaints, for example, about adult social care providers. As part of our scheduled inspection to see whether the provider was meeting the regulations, we looked at people's care records. Some records we requested to look at could not be located and some care records did not contain the information staff needed for information about people's care needs. One person's food chart was not an accurate record of what they had eaten.

People had their prescribed medicines available to them; however, prescribed items were not always safely managed by staff. For example, creams and eye drops were not dated on opening. The manager could not be sure people always had creams applied as prescribed because records were incomplete and no effective system was in place to check.

Risks associated with people's care had been assessed and actions were described to reduce the risk of injury and harm, but these were not always followed by staff.

The storage arrangements of some medical items presented a risk of contamination or infection. Areas of

the home were visibly dirty. Some areas of the home were in need of maintenance. For example, we found torn lino in a kitchenette that prevented effective cleaning.

Staff had completed some training to deliver care and support but there were no checks or assurance they had training that had equipped them, with the skills or knowledge they needed to undertake their roles. Staff had a limited knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and staff were not aware of their responsibilities under this Act.

Most staff had a caring approach to people and were kind and compassionate. People were not always treated with dignity. People and their relatives were involved in making choices or decisions about their care.

Most staff knew people's needs, however, people's care plans did not always contain the information for staff to refer to if needed. Staff did not always respond to people's needs. Social activities took place as planned for and people were offered choices about their food.

Some systems were in place to assess the quality of the service provided but these were not effective. We found there was insufficient oversight, from the provider, to check delegated duties had been carried out effectively.

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

You can see what action we told the provider to take at the back of the full version of the report.

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 had their prescribed medicines available to them but systems to ensure safe management of medicines were not always followed by staff. Risks associated with people's care had been assessed and actions put into place to reduce the risk of harm, but were not always followed by staff. The provider had not always updated, or maintained records, of the required pre-employment checks to ensure staff were of good character. There were risks of infection because storage arrangements were not suitable and clean. The premises were in need of some maintenance to ensure a safe and secure environment for people to live in.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had completed some training to deliver care and support but this had not included all they needed to give them the skills or knowledge they needed to undertake their roles. Staff had a limited knowledge of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were offered choices with meals and were referred to health professionals when needed, but professional visits were not always recorded by staff which meant details of visits could not be referred to if needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most people and their relatives told us that staff were kind and caring towards them or their family member and we observed examples of this. However, some feedback from people showed staff were not consistently caring. Staff did not always maintain people's dignity. People and relatives were involved in making choices or decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that was personalised to them. People's care plans were not always detailed to support staff in delivering care in accordance with people's needs. Planned group activities took place as planned for, which people told us they enjoyed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had systems in place to monitor the quality of the service but had not ensured these were effective. This meant there were a number of shortfalls in relation to the service people received and actions had not been taken to drive improvement. Records were not always accessible and not always stored securely.

Willow Tree 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.

The inspection took place on 1 and 2 March 2016. The visit was unannounced on 1 March 2016 and we told the provider we would return on 2 March 2016. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service.

The provider had not completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We discussed this with the registered manager and they informed us they had not received a PIR request from us.

We reviewed the information we held about the service. This included information shared with us by the local authority and the local government ombudsman. We reviewed notifications received from the provider, for example, safeguarding alerts. A notification is information about important events which the provider is required to send to us by law.

Some people living at the home were not able to verbally communicate with us about how they were cared for. However, we used the short observational framework tool (SOFI) to help us assess if people's needs were appropriately met and if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who, due to their frailty or health conditions, could not talk with us.

We spoke with 10 people and spent time with other people in the home. We spoke with eight relatives who

told us about their experiences of visiting the service. We spoke with staff on duty; including one nurse, three care staff, one agency nurse, three agency care staff, the cook, the maintenance staff member, the activities staff member, Oak care manager, the registered manager and the care home support manager. We spent time with care staff and observed them offering care and support in communal areas of the home.

We reviewed six sets of care records and a range of key elements in 16 other people's records which included medicine administration records, food and drink charts and re-positioning charts. We did this because concerns about accurate completion of records had been shared with us. We reviewed three staff employment induction, training, support and employment records, quality assurance audits and minutes of staff team meetings.

Inadequate

Our findings

Some people were able to tell us that they had their medicines given to them by the nurse. We observed the nurse administering medicines to people and saw they did not rush people and explained to them what their medicines were prescribed for. We heard one person tell the nurse, "I am in pain." The nurse reminded the person when they last had their pain relief and at what time they would next be able to have more pain relieving medicine. A further person told us, "I am in so much pain." We notified the nurse of this and saw they gave the person some of their 'when required' pain relieving medicine. This showed that the nurse responded to people's requests for their medicine.

Medicines were available to people as prescribed by their GP and most were stored safely. Medicine trolleys were locked and secured to a wall in the corridor. A nurse showed us a designated lockable room that was used to store stocks of medicines.

We looked at the medicine administration records (MAR) for ten people. We saw most medicines had been signed for when given to people but there were gaps in the records and it was not clear whether people had received their medicines as prescribed. The nurse told us they had recently been on leave and could offer no explanation for the gaps.

Some people had medicine prescribed to be given 'when required' or 'as directed.' For example, one person's eye drops stated to apply 'as directed' but we found no protocol in place to inform staff which eye to administer the medication to. The MAR and the pharmacy label on the medicine also did not state which eye. There was no care plan for the person's eye care needs. Whilst the nurse on shift was able to tell us which eye the drops should be applied to, the information was not available to non-permanent, agency nurses.

Topical medicines such as prescribed creams or eye drops being used were not dated upon opening; this is important as some topical medicines have a limited time to be used once opened. One person's eye drops had a prescription date of November 2015; we saw the bottle was in use, but nursing staff had not recorded a date of opening the bottle. We discussed our concerns with the manager and they replaced the bottle. We saw quantities of creams were stored in people's bedrooms and those in use had no date of opening. For example, one person had a tube of cream with a prescription date of February 2015 and the tube of cream was in use by staff. We discussed this with the manager and they said, "Staff should write dates of opening on these in line with the manufacturer's guidance."

We found no record to show creams were applied as prescribed. We discussed this with the manager and they told us, "Carers apply creams to people as needed, but there is no administration record signed." Some care staff told us they applied creams if they were in people's bedrooms but a few told us they would not apply creams unless specifically instructed to do so by the nurse. This meant we could not be sure people received their prescribed creams as required to treat or protect their skin from becoming sore.

Whilst speaking with one person in their bedroom, we observed a bottle of prescribed eye drops on their table. The person told us, "The nurses give me most of my medication, but I do my own eye drops. I've got this as well." They showed us a further medicine that we saw had been prescribed in December 2014. We found the person's MAR had no record of self-administration. The manager had informed us that no one at the home was self-administering their medicines. We discussed our observations with the manager and they told us, "I was unaware of anyone having their own medicines, I'll look into this."

The manager informed us that seven people received their medicines 'covertly'; hidden with their food or drink without their knowledge. We looked at two MARs for people that we were told had their medicines in this way and saw staff had sought authorisation from the person's GP. However, no details about how medicines should be given covertly were recorded and we discussed this with the manager and a nurse. The manager told us, "We sometimes do take advice from the pharmacist about how it should be taken." The manager said they could not be sure whether advice had been sought from the pharmacy as it was not recorded. This meant that nurses; including agency nurses who did not know people well, did not always have the information they needed to tell them how people's medicines should be given to them covertly or if they were safe to mix in with food products.

Some people living at the home had been prescribed food supplements, by their GP, to increase their calorific intake; to increase their weight. We found a quantity of individual food supplement drinks in a dirty kitchenette cupboard. One staff member told us. "The food supplements are the ones allocated to people for today." We found the food supplements were not labelled and the storage was not clean or secure. We found one bag of food, alongside the food supplements, contained a food item that had green mould growing on it. We discussed this with the manager and they said, "I'll dispose of that, I think it has been left by staff." We saw the item was disposed of and on day two of our inspection visit we saw the cupboard had been cleaned. However, food supplements remained unlabelled, so it was not clear who they were prescribed for.

The manager told us that they planned to assess nurses' competency in medicines administration by observing their practice. Records showed only one competency assessment that had been completed by a previous manager. The manager explained that planned dates were a 'work in progress' and they had not completed them yet.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found staff did not understand, or follow, good practice in infection prevention and control procedures and identified a lack of safe infection control in the home. In the main kitchen we saw dirty fly screens in place, stained ceilings, and cobwebs and dust on the extractor fan that were at risk of falling into and contaminating food items. We found there was a lack of effective cleaning at high and low levels in the kitchen. The cook told us cleaning schedules were in place, but they had to focus on people's meal preparation. They told us they had no kitchen assistant to support them with their work since December 2015. The manager said, "There used to be a kitchen assistant to help the cook but they left; before Christmas 2015. There are no current plans to replace them." We found there were not enough staff

allocated to cleaning tasks to ensure food was prepared, and served, in a food safe environment.

On day one of our inspection visit we saw spillages and food debris in the Cedar kitchenette which had accumulated in drawers, the fridge and on the floor. On day two we saw some areas of the kitchenette had been cleaned but remained stained. Some food products, such as 'sweetener' had been decanted into dirty containers that were not labelled. We asked the manager to dispose of one uncapped juice bottle stored under the waste pipe; which they did. Some cutlery in a drawer, ready for use, was dirty with dried food on items which showed cleaning was not effective.

In people's bedrooms, their clinical items such as prescribed dressings were stored in open boxes on the floor and some were uncovered and stored in people's en-suite. In one bedroom we found unused catheters and tubing in a dirty open box on the floor, the clinical items did not belong to the person whose bedroom it was as the manager told us they did not use a catheter. The manager said they were unsure who they belonged to and had probably been stored there. They said they would dispose of the catheter bags, which they did. We found quantities of unused incontinence pads were stored uncovered in people's bedrooms and corridors of the home. We discussed this with the care home support manager who told us they would purchase some plastic lidded storage boxes.

Bed rail bumper covers were dirty and sticky to touch. Some foam-filled plastic covered mattresses, used as 'crash mats' next to people's beds were torn which meant that it would be difficult to effectively clean them.

We observed two housekeeping staff members cleaning people's bedrooms and saw water that was being used to mop en-suite floors was dirty. When we pointed this out to one staff member they said, "Yes, it looks dirty black water now. I'll change it soon." Training records showed us most of the staff team, including housekeeping staff, had not received training in health and safety and infection control measures and our observations showed staff did not recognise the importance of preventing risks of cross infection. No checks were in place to monitor staff performance and ensure that staff, who needed infection prevention skills and knowledge, were provided with the training.

Some areas of the home were in need of maintenance. Some carpeted areas were worn and stained. A shower chair, clinical waste bin and storage rack were corroded and rusting. Staff told us there was a book where they could log issues requiring maintenance attention and we saw this was in place, but had not recorded issues we identified. The maintenance staff member told us they were not aware of, for example, cracks in one person's bedroom walls and sink tiles but staff had informed us the damage was not new.

This was a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they felt safe living at the home. One person told us, "I feel safe because I know staff are about." However, a few people told us they did not always feel safe at night because other people had entered their bedrooms. One person told us, "Another resident came into my bedroom at night and it frightened me, but staff came when I pressed my buzzer." Another person told us, "I feel safe here, but one resident continually comes into my bedroom and wakes me up at night. It's not their fault, they are not well. I've mentioned it to staff before, but it still happens." We discussed this with the manager and they told us, "We have recently relocated one person to a different bedroom, in consultation with the family members, and this will mean staff at night can observe them more closely."

We saw risks to people's safety had been assessed and observed some staff followed actions to safely

transfer people from their wheelchair to armchair using a hoist following safe practice guidance. However, we saw some poor practices involving moving and handling which could cause risks of harm or injury to people. For example, we intervened to stop staff lifting one person under their arms to transfer them from their chair to stand with their walking frame. Some staff told us, and records confirmed, they had not received training to safely move and handle people, but had been shown techniques by other staff members. We found this was not effective because the risk of harm or injury to people was not minimised by the techniques some staff used.

One person told us, "One staff member gripped my forearms to help me get up and their finger nails broke the skin on my arm." They showed us their arm that had a dressing in place. We asked to look at the accident form but the manager was unable to locate it for us.

Some people had bed rails (sometimes called bed sides) in place. Risk assessments were in people's care records for the use of their bed rails and for them to be used with 'bumper covers' to reduce the risk of injury or entrapment. On day one of our inspection we observed one person in bed with bed rails, but one side had no 'bumper cover' in place. We pointed this out to the manager; whilst in the person's bedroom and they said, "Staff should use the bumper cover," but the manager did not put the 'bumper cover' into place and did not ask another staff member to do this. Bed rails are 'medical devices', which fall under the authority of the Medicines and Healthcare Products Regulatory Agency (MHRA). We found MHRA guidance on the 'Safe Use of Bed Rails' was not always being followed by the provider.

This was a breach of Regulation 12 (1) (2) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people and their relatives told us there were not always enough staff on duty to meet their needs. One relative told us, "It varies." Staff told us the provider always allowed agency staff to be used whenever needed. On both days of our inspection visit we saw agency staff had been booked and were on shift. However, one relative said, On [date] there were insufficient staff on shift and no agency staff." The manager told us, "If staff telephone in sick at late notice it can be hard to cover shifts with agency, but efforts are made to ensure sufficient numbers of staff are on shift to meet people's dependency needs." One staff member told us, "The problem is the skill mix of staff. We might have the right allocated number of staff, but take today for example, the skill mix is not right and it's impacting on people's care."

We observed three people were supported to get up from bed at 11.30am. One staff member said, "Three people would have liked to be up earlier, but the skill mix is all wrong today. It's not always like this, but sometimes smarter thinking would do the Oak and Cedar staff allocation differently to spread experienced staff equally." We discussed this with the manager and they agreed that the skill mix, they had allocated to Oak and Cedar, on day two of our inspection visit was not working effectively. The manager explained that this was partly due to some staff attending training that day and there was a high use of agency staff.

Staff meeting minutes recorded that some staff had raised concerns about a lack of time to undertake tasks, such as supporting people to have a bath or shower. We discussed issues that had been raised by staff with the manager and they informed us personal care tasks should be completed before mid-morning, but baths and showers could be fitted in at any time. The said some staff were new and had been 'slow' whilst getting to know the routine. We found no plans were in place to consider how to improve the situation; such as an additional staff member at busier times of the shift.

We saw steps had been taken to interview and take up references for new staff but found the provider had not adequately checked staffs' suitability for their role when they recruited. One staff member told us, "I

started here this year. I know I had an interview and gave names for references but they told me I didn't need to have a police check." We looked at three staff employment records to see whether checks had been made by the provider to ensure staff were of good character. We found one new member of staff had a Disclosure and Barring Service (DBS) certificate dated December 2015 from previous employment. We found no record of a risk assessment or discussion to document the acceptance of the previous employer's DBS check. We found no record of their induction or supervision on starting their employment. The care home support manager told us a new DBS would be requested.

The DBS is an organisation that holds details about people's criminal records. There were no records of DBS checks on the other two staff employment records we looked at. We discussed our concerns with the manager and requested the records to be sent to us the day after our inspection visit. One record was located and the DBS was dated 2010. We discussed this with the provider and they told us no further DBS check had been made but staff were requested to sign an annual declaration to say they had no criminal record. The other DBS record was not located by the provider and they stated they would immediately apply for a DBS check for the staff member.

Requires Improvement

Our findings

Most people and relatives felt that staff had the skills and knowledge they needed for their job roles. However, a few people and their relatives gave us examples of poor care practices.

We found that improvements were required in the training and support given to staff to ensure they were sufficiently skilled to meet people's needs effectively.

Staff told us they had received an induction, when they started working at the home, which involved working alongside experienced staff members for a 'couple of shifts' and had received some training. One staff member told us, "The training is very good here." Another staff member said, "Some training is 'on the job' here, such as using the hoist."

Some staff identified training needs to us that they felt they would benefit from, such as caring for people with dementia, moving and handling, safeguarding people from abuse and first aid. From speaking with staff and observations of care practices, we found staff did not always have the necessary skills or knowledge for their job roles. The manager told us that they, and another member of staff, were moving and handling trainers. Due to our concerns about some poor practices with moving and handling techniques, we asked if we could look at the certificate of training but the record could not be located so we could not evidence they had completed the moving and handling 'train the trainer.'

We saw a number of gaps in the staff training matrix which the manager kept as a record of training undertaken. The manager confirmed that some staff, including long standing and newly appointed staff, had not completed all of the training they needed. The manager said they needed to address the gaps but did not yet have a plan in place to show to us.

During our inspection visit over two days, we saw an agency nurse and agency care staff were on shift. We received mixed feedback from agency staff about their induction into the home and people's needs. The agency nurse told us, "I attended handover and feel I have the information I need about people, plus there are employed staff here I can ask." Two agency care staff told us they were orientated around the building but only received information about people's needs and tasks to undertake, from other agency or employed staff, as the shift progressed because they had not attended handover from the previous shift. One agency staff member told us, "I've never worked here before and have not had any handover or information about people, but I will ask if I am unsure." The manager informed us that there was no set induction information given to agency staff and said, "It's been informal, with no record made of what agency staff have been told.

It's something we could develop. We try to use the same agency staff whenever possible so there is some continuity for people here."

Closed Circuit Television (CCTV) was used in corridors and parts of communal areas of the home. There was a notice to inform visitors entering the home that CCTV was in use. We discussed the use of CCTV with the manager and they informed us, "The images are live and displayed in the office, but as far as I know, they are not recorded. I'm not really sure why it's in use, I think it might be to make sure staff don't spend time chatting to one another." We found the service user guide about the home did not refer to the use of CCTV and asked the manager how people living at the home were informed about its use. The manager said, "I don't think that's been considered. There is nothing about consent in their care records." This meant that the registered manager and provider were not meeting their responsibilities under the Data Protection Act to inform people of the use of CCTV.

Most staff could not tell us about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), and could not recall any training on this. The Mental Capacity Act 2005 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 are called the Deprivation of Liberty Safeguards. Staff said they would not force people to do things and tried to give people choices whenever possible. We found staff had a limited knowledge of the principles of the MCA and DoLS and were unclear about their responsibilities.

Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documents in their care record. We saw a few recorded a discussion with the person had taken place, but where decisions had been made by family members or GPs, there was no record that a mental capacity assessment had been completed. We found one person had a DNACPR in place and saw this conflicted with their recorded wishes to be resuscitated. We found no mental capacity assessment had been completed for the person. We discussed the conflicting records with the manager and they could offer us no explanation. This meant that the provider was not acting in line with the requirements of the MCA.

One person's care records told us they had a DoLS in place to ensure they received all the care and treatment they needed. However, we found no mental capacity assessment or 'best interests' meeting had taken place. We saw that another person, living with dementia, had been cared for in bed since October 2014. We found no mental capacity assessment or 'best interests' meeting had taken place to decide this and no DoLS was in place. We looked at two sets of records for people that received their medicines covertly. Care records contained a GP letter of authorisation but we found no mental capacity assessment or 'best interests' meeting had taken place.

The manager showed us that some people had an authorised DoLS in place, and further applications had been made. Records told us that of the 39 people living at the home, seven had an authorised DoLS in place and a further 16 referrals had been submitted to the local authority; without people's mental capacity being assessed first. Most staff were not able to tell us who had a DoLS in place and none of the staff could tell us who had a pending DoLS application. One staff member said, "I wouldn't let anyone out of the building, it would not be safe for them." We saw that key code locks were restricting people's movement within Oak and also at the front door to the home. This meant staff restricted the liberty of some people without the proper authority to do so. This meant that the manager and provider were not acting in accordance with the

requirements of the MCA 2005.

This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the meals were 'good'. One person told us, "The food is lovely here." Another person said, "I had gone off my food, my appetite was low. But, now I am eating better and enjoying the food." One staff member told us, "I ask my team (in Oak) to offer people a choice of meal by showing them plated food." We saw this happened in Oak. In Cedar, people told us they were verbally given a choice of meal. We observed staff support people, in Oak and Cedar, with their meals when needed. We saw most meals were well presented and appetising. However, a few people that required a pureed food diet had their food pureed all together into a brown liquid in a bowl. The cook told us, "It looks unappetising, but I've been told to do it like that by the manager." The manager agreed that improvements could be made to the presentation of people's pureed meals by separating food items when blending to the required consistency.

We observed meals were served hot but were taken, uncovered, to some people in their bedrooms. We saw staff carried meals past open clinical waste bags in the corridor. We discussed our concerns about hot meals becoming cool and the risks of contamination with the manager who agreed it would be good practice to cover meals and using the covers available. On day two of our inspection visit, we saw staff covered people's meals whilst taking food to them.

In Oak lounge, people were supported, by staff, to enjoy homemade cake and snacks. People were frequently offered and supported with drinks. However, in Cedar lounge a bowl of fruit was available but was not close to people and they could not help themselves. One person told us, "That fruit is always there, I don't know whose it is." Throughout our inspection visit we did not observe staff offer anyone the fruit. On both days of our inspection, we saw that jugs of squash and glasses were available in Cedar lounge but most people did not have drinks close to them and could not help themselves. In Cedar, we observed people were not offered drinks as frequently as they wished. One person told us, "I've been waiting for a cup of tea since breakfast. It is very late (12 noon)." A staff member informed us, "Staff are one hour late today with the tea trolley. Really staff should leave people with a glass of squash on their table, it's no good just leaving on the table at the end of the lounge really." On day two of our inspection, we observed people on Cedar were offered their mid-morning drink at 12.00 noon and available snacks such as cake were not offered to people as staff said it was too close to lunchtime.

Some people seen had been identified as at risk of malnutrition and / or dehydration and were dependent on staff supporting them with food and drink. Staff informed us that food and drink charts were in kept for some people that were identified as at risk so that their intake could be monitored. We found one person's record recorded they ate 'all' their lunch but we had observed the staff member throwing most of the person's meal in the bin. This meant the food record was not accurate. We informed the manager about this and they said staff were responsible for completing the charts. We found there was no effective check of people's food and drink records.

Relatives told us they felt confident staff would ask for a GP to visit if their family member was unwell. One relative said, "I am very happy with my relative's care here. They'd get the doctor if needed." Care records showed that referrals to healthcare professionals had been made when needed, such as to dieticians, speech and language therapists and GP's. Staff informed us that people received chiropody, optician and dental visits at the home from visiting professionals. One relative told us, "My family member recently had new glasses."

Care records did not always contain dates of health visits. One person's care record for example said, in November 2015, they needed to see the chiropodist but we found no record to confirm if their needs had been attended to. The manager told us, "Staff might have put it in the daily notes and forgot to put it in professional visits; the daily notes might have been archived. I'll remind staff to put such details on the professional visits record." The manager was unable to locate a record to show person's chiropody need had been met. During our inspection visit, staff did not check the person's toenails to establish whether their needs had been met.

Requires Improvement

Our findings

We received mixed responses when we asked people if staff were caring. One person told us, "I think quite a few care staff go the 'extra mile' and really care for me." One relative described staff to us as, "Very friendly and very caring." We observed some kind, respectful and friendly interactions between staff and people living in the home. One staff member took time to patiently support one person with a drink and engaged with them during the task, despite the person being unable to verbally communicate back with the staff member. We observed one nurse supporting people to take their medicine and they took the opportunity to engage with the person in a kind way, offering gentle support when needed. Most staff made sure they were at the same height when they spoke with people and used respectful language.

One staff member told us, "I always try to be an example to the staff team of what caring is and explain how this should take place when supporting people living with dementia. It is so important that we enter their world and whatever age or time they believe they are in, we go into that and not make them come to our time, that would not be caring." Records showed some staff had received dementia care training and we observed some care practices, on Oak, that demonstrated staff had a good understanding of caring for the specific needs of people with living with dementia.

Some peoples' and relatives' comments suggested to us that improvement was required in staff consistently showing respect toward people. For example, one person told us, "The staff are very caring, but there are one or two that call me names. I laugh it off." We asked the person if they had reported this and they said they knew who the manager was but had not reported it as they decided to 'laugh it off'. One relative said, "The majority of staff are kind and caring but I did observe one staff member was extremely rude to one person." We asked if they had reported this but they said they had not, but had spoken with the person living there and asked if they were alright.

One person living at the home said, "The staff are caring, but sometimes have too much to do. Sometimes I see staff spend more time with people that don't need it, than others that need the care from them." We saw a few staff, in Cedar lounge, walk past one person who needed support with a tissue. We saw staff walked past a few people that had finished their meal but were not supported to remove food spillage soiled aprons.

Some people we spoke with could recall being involved in decisions about their care, a few told us they thought their relative was involved on their behalf. One relative said, "I have been involved regularly with my family member's care."

Most people told us they felt staff respected their dignity. We observed staff maintained people's privacy, when undertaking personal care tasks, by closing bedroom doors. However, we observed times when staff transferred ladies, who were wearing skirts, from an armchair to a wheelchair, using a hoist without placing a blanket over their legs to maintain their dignity. We suggested this to two staff members and one said, "There might be some blankets in the laundry cupboard, it's a good idea for ladies that want to wear skirts." However, we observed the same staff continued to transfer ladies failing to maintain their dignity.

We saw people's bedrooms were personalised and contained items, such as photographs, that were important to them. One staff member said, "I try to make sure people's bedrooms are as pleasant as possible for them. If they do not have their own pictures, I offer to make them some." The staff member showed us framed images of a location important to the person that they had made for them. Two other staff members showed us images of film stars and films from the 1930s, 40s and 50 that they had made to decorate Oak corridor. This showed us that staff took an interest in the environment of Oak and contributed to making it interesting and homely for people living there.

One staff member informed us, "We've made suggestions about how to improve the environment to make it more dementia friendly so people have information in a way they understand. For example, by using different colours along the corridors people could orientate themselves to their bedrooms because they understand the colour means where their bedroom is."

Requires Improvement

Our findings

We asked people if staff were responsive to their needs and we received mixed feedback. One relative said, "I feel staff meet my family member's needs."

We spent time in communal areas of the home observing the support people were given and the responsiveness of staff to people's needs. Some people were unable to verbally communicate with us or re-position themselves, but we saw some looked uncomfortably positioned in armchairs. For example, one person was positioned awkwardly in their chair so that their head was not supported by the chair or a cushion. On day one of our inspection visit, we saw some people in Cedar lounge were sitting with their feet hanging down not reaching the floor and their feet were not placed on foot rests. We saw staff did not respond by getting people cushions or foot rests to ensure they were comfortable. We discussed this with staff and the manager and saw on day two those people had chair foot rests in place but a few other people had been left with their feet not reaching the floor. We pointed this out to one staff member and they placed the person's feet on a low level foot stool. This showed us that whilst staff acted positively when issues were identified by us, staff had not always checked with people that they were comfortable or assessed whether needs were met, where people could not verbally tell staff.

A few relatives felt their family member's personal care needs were not always met. One relative said, "I'm not sure how often my family member has a shower, sometimes I find their nails are dirty." We observed some people's fingernails were long, with dirt embedded under them. One staff member said, "Some people don't like personal care very much." We pointed this out to the manager on day one of our inspection visit and they told us, "I'll get that sorted out." However, on day two of our visit, we saw the same people still had long and dirty fingernails.

Staff were present in communal areas, such as lounges, most of the time, so they were accessible if people required them. However, there were times when staff were not present and we saw that the call bell cord to call for support, for example in Cedar lounge, was not accessible. Where some people were cared for in bed, call bell cords had not always been left accessible; that is clipped onto the bed covers, so that people could attract staff attention when needed. We pointed out to one staff member that we had found one person's call bell on the floor and they told us they must have forgotten to check it was left with the person. Although we saw that two hourly checks were made by staff on people in their bedrooms, these were not always effective in ensuring people were left with call bells where they were able to use them.

We discussed this with the manager who explained that some people would not be able to use call bells.

However, we found no assessment was in place to determine whether people could use call bells and no consideration had been given, where people were said, by staff, to be unable to use call bells as to whether the two hourly checks were sufficient to ensure people were responded to promptly.

Care records contained an initial assessment of people's needs. One relative said, "When my family member moved here, staff asked me about their likes and dislikes with food and what they enjoyed doing." Care records showed that people and their relatives were offered an opportunity to share information about a person's life history, preferences or wishes so that staff had the information they needed.

People's care needs were identified in a care plan, but we found some lacked detail. For example, we observed one person occasionally hit out at staff. We saw one staff member clearly and slowly explained to the person that they were going to help take off their cardigan, we saw the person did not hit out. The staff member said, "I've found good communication works well with them and reduces them hitting out." However, we observed on other occasions, where no prior communication with the person took place, that they hit out at staff. We found the person's care plan described that they could be 'aggressive during personal care' but gave no guidance on what approach by staff worked most effectively in responding to their needs.

We looked at care plans to see how people's specific health care needs were identified and monitored. We saw one person's care record showed their blood pressure needed to be monitored on alternate days. We saw this had been done once when the person arrived for their short stay at the home and had been done once again by the GP. However, we found no other record of the person's blood pressure being monitored as planned. We discussed this with the manager and they could not offer any explanation for this. We saw some people were diabetic and needed their blood sugar levels monitored. However, we found there was no guidance as to what the person's individual desired range should be. The nurse said they would call the GP if they felt the person's blood sugar was too low and seek advice. This meant staff could not refer to information, if needed, to know when the person's blood sugar level created a risk of harm to their health.

Staff told us that a church Holy Communion weekly service was offered at the home for people who wished to attend. One person told us, "I always go to the church service, it's good they have that here." Staff informed us that the arrangements currently met the religious needs of people who wished to practice their faith, but if people had other religious beliefs staff would seek to find a community link to meet their needs. Group activities were planned and took place. We observed the activities staff member and other staff members engage people in soft ball games, puzzles and reminiscence games on both days of our inspection visit. Most people told us they felt there were enough activities offered to them at the home. However, a few felt their individual needs were not met. One person told us, "I like to read and there are books here but I nothing I can read. They are unsuitable children's books." Another person said, "We only really get to go out in the summer when we can go out on the garden patio." This meant that improvement was needed, for a few people, so they could maintain their individual hobbies and interests.

We asked people and relatives about what they would do if they wanted to raise a concern or were unhappy about an aspect of the home. Most relatives told us they had no complaints. One relative said, "I've no complaints. I'm happy my family member is here." A few relatives told us they identified minor concerns but had not raised these with staff. A few relatives said they raised issues with staff when needed and these were dealt with. For example, one relative told us, "Sometimes when I visit, I find my family member's clothing is wet. I tell staff and they always change [Person's Name]." We saw details of how to make a complaint to the provider was included in the service user guide.

Requires Improvement

Our findings

There was a management structure in place at the home with a registered manager and deputy manager. The manager told us, "Plans are in place to appoint someone to a clinical deputy post this week. This will be supportive to me in my role." The manager informed us they had previously worked at the home as a nurse before becoming the manager in August 2015 and registered with us in October 2015. The manager said they felt supported by the care home support manager and provider. They told us, "The care home support manager visits frequently and can also be contacted by telephone if needed." We asked whether the care home support manager undertook quality assurance audits of the home but were told these were not done, but they looked at the ones completed by the manager and senior staff in the home. We found that the care home support manager and provider had a lack of oversight of the home.

Staff told us they felt the manager was approachable and did listen to them but did not always act upon issues identified. One staff member told us, "I can see Cedar kitchenette needs refurbishing, I've previously told management, over a year ago, but nothing happened." Another staff member said, "We did some lovely collage art work with people and I've asked the manager for a frame several times but nothing has come of it." We discussed this with the manager and they said they had received a donation of money from a family that they could use for a frame and thought the staff member had been aware of this. We discussed this with the manager and they said effective communication may not have taken place with staff.

Systems and processes were in place to audit, the quality of the service. Some audits had been completed but we found these were not always effective. For example, an infection control audit, completed in December 2015 by the manager, had not identified any issues we identified, such as torn lino in Cedar kitchenette, a corroded bin, shower chair and storage rack had not been identified in this or any other audit, such as maintenance.

In the most recent health and safety audit of September 2015, some actions had been identified as requiring immediate action, such as to check staff had received health and safety training. However, we found gaps remained in staff training. We found other areas identified for action was required within three months. This included fire safety and the need for all staff to have attended an annual fire drill. Whilst speaking with staff about emergency procedures, they told us they would assemble at the fire panel but no staff member told us they would phone the emergency services. An unannounced staff fire drill in January 2016 recorded 'no single member of staff took control'. We discussed this with the manager and asked what action they had taken and they told us, "We plan to have monthly fire drills to make sure staff know what to do." We found the provider had not taken timely action to ensure staff knew what to do in the event of a fire.

A medicines audit, completed in February 2016 by a senior staff member, had not identified the issues that we found. For example, we saw the audit recorded creams were stored safely in people's bedrooms but had failed to identify they were not dated on opening. The audit recorded 'not applicable' to people keeping prescribed medicines in their bedroom but we found one person was self-administering prescribed medicines.

The manager told us accidents and incidents were recorded and analysed for trends and patterns or to prevent reoccurrence. Staff told us and we saw that some people had pressure sensor mats in place to alert staff if needed. This meant that actions were taken to reduce the risks of repeated accidents from happening.

The manager informed us that spot checks of staff competencies were informal but they planned to formalise these and include medication competency assessments for nurses. Staff told us they had one to one supervision meetings but these did not always take place as planned. One staff member told us, "I think we have about one a year." Another staff member said, "They are not as frequent as I think they should be." Staff told us they did not have annual appraisals and the manager confirmed this to us and said, "The provider's policy is for supervisions only and not for appraisals." We discussed gaps we identified in most training topics on the staff training records with the manager. For example, none of the nurses had completed MCA or DoLS training. The manager said staff had not completed all of the training topics and further training was needed. There was no system to check that staff had the training they needed or whether it was effective and provided staff with skills and knowledge they needed for their roles.

'Resident and relative' meetings were arranged and took place, the manager showed us the most recent meeting notes which we dated July 2015. Some people told us the staff asked them if they were alright but could not recall management seeking their views. We discussed this with the manager but they could not recall when feedback was last sought from people or their relatives. A 'suggestions, comments and complaints' leaflet was available in the reception area of the home. However, the manager could not tell us whether they had received any completed feedback from relatives. We asked whether the provider sent feedback surveys to people and / or their relatives. The manager was unable to tell us whether this was done, so we asked the provider. The provider was unable to locate any formal feedback from people or any analysis or action plan following feedback from people. The care home support manager was unable to tell us when feedback was last sought from people, which meant opportunities may have been missed to improve the service provided, when needed.

The manager informed us they had received three complaints since our last inspection in April 2014. We discussed one complaint, made in March 2015, with the manager. They informed us this involved an incident when a person's needs were not responded to. The manager said that although this was before they were registered manager of the home, they thought they had spoken with the relevant staff in supervision but we found no record of this. The manager was not able to offer any explanation to us about this.

The Local Government Ombudsman had informed us, in November 2015 that a complaint had been received by them. As an outcome of the complaint, the provider's had been required to share an action plan with us to tell us how improvement was to be made to care records and communication. The provider's actions set out time scales from 30 November 2015 to 4 January 2016 during which time actions to improve would be implemented. Some records that we requested were not located over the course of our two day inspection visit or the day following our inspection. Records requested but not located included an accident form we wanted to look at, one staff member's DBS check, one staff member's supervision record and feedback from people and their relatives. We found planned improvement to care records had not been

implemented effectively.

Planned improvements, by the provider and manager, included care records for people on short stay 'respite' at the home. Improvement to these was to ensure people's needs and risks were identified and responded to. We looked at one person's respite care record and found their needs were identified but no record of an identified health need being responded to. Planned improvements included training staff on recording information such as nutritional intake, we found this had not been effective as one staff member recorded 'all' a meal had been eaten when we saw most was thrown away. This meant the provider could not be certain people were having sufficient to eat and drink.

We looked at care records for people who had recently moved into the home and found some care records had not yet been completed. We saw one person had a catheter in place but they had no catheter care plan. We asked the nurse and manager about the person's clinical needs for their catheter and when it had last been changed. They told us the person had been admitted to the home from hospital with a catheter in place but could not tell us the reason why. The manager said they would contact the GP for this information. The nurse and manager agreed that a catheter care plan should be in place to ensure records were kept about the person's catheter changes.

We looked at the MAR for one person who was prescribed food supplements and saw a code had been recorded instead of a staff signature which indicated they had not been given their supplement as prescribed. There was no information to tell us why nursing staff had entered a code, indicating 'other,' and a nurse we asked could not give us any explanation. Throughout our inspection we observed people's medication records were left unattended and unsecured in a corridor on top of medication trolleys. This meant people's personal information was accessible to people not authorised to look at it.

Appropriate storage arrangements were not in place at the home. We saw one person's bedroom was being used to store a bed, four chairs and a large unopened parcel addressed to the 'care manager'. The manager told us the bedroom was a twin room, but had not been used as such since before August 2015. Laundry trolleys, containing new incontinence pads and an open clinical waste bag, were stored in corridors. We identified that unattended cleaning trolleys were left in people's bedrooms, including one trolley left next to a person in their bed. The manager said, "We do have a problem with storage here, but trolleys should not be left in people's bedrooms by cleaners, I'll remind them."

The registered manager told us, "There is no refurbishment plan to my knowledge, but I agree some areas and equipment are in need. The maintenance man does some painting when needed and completes some health and safety checks, but I've not been notified by the provider to ask them to do anything else." This meant that décor issues had not been identified as requiring attention and risks, such as Cedar lounge external door, not fitting well and allowing cold air in through the gap, were not addressed.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) (d) (ii) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We gave feedback to the manager at the end of our inspection and they said, "I'm planning to have a meeting, this week, with the care home support manager to work out a plan so improvements can be made." Following our inspection visit, the care home support manager shared an action plan with us; to address the issues identified to the manager over the course of our inspection visit and during our final feedback to them. We saw that the plan recorded some actions had already been implemented and further actions to make improvements were planned for, and time scales for implementation were given to us.

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 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) The manager and provider were not acting in accordance with the MCA 2005

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 Regulation 12 (1) (2) (g) The provider did not always have a safe management of medicines system. Regulation 12 (1) (2) (h) The provider did not take measures to prevent and control the risks of infection. Regulation 12 (1) (2) (a) (b) (c) the provider did not always assess risks or take action to mitigate such risks. The provider did not ensure service users were cared for by staff that had the qualifications, competence, skills and experience to do so safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 (1) (2) (a) (b) (c) (d) (ii) (e) The provider did not have effective systems or processes in place to effectively ensure compliance with the regulations.