Bupa Care Homes (BNH) Limited

Ardenlea Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This inspection took place on 10 April 2017 and was unannounced. At our last inspection on 17 and 19 May 2017 there were three breaches of the Regulations. These were for Regulation 18, Staffing; Regulation 9, Person-centred care; and Regulation 12, Safe care and treatment. During this visit we found some improvements had taken place, but there were areas which continued to require improvements from out last visit, and other concerns identified.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve all the key questions to a rating of 'good'.

Ardenlea Court is a 'care home' which provides nursing care. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home provided support to people with physical disabilities and people who live with dementia. The ground floor provided permanent residency to eight people, and an Intermediate Care Unit (ICU) comprising of 18 beds. The ICU provided beds contracted by the NHS for people who were ready to leave hospital but required further assessment to determine their longer term needs. These are termed 'discharge to assessment' beds. The first floor provided a maximum of 29 beds for people who lived with dementia. On the day of our visit 51 of the 55 beds were occupied.

The home had a registered manager. 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. The registered manager was new in post and had been registered with the CQC in February 2018.

Since our last inspection the management team at the home had changed. The previous registered manager and deputy manager left at the end of 2017, and a number of staff left around the same time. Up until the departure of the previous registered manager and deputy manager, we were informed there had been improvements at the home; but on the departure of key people, the standards of care and treatment had again slipped.

At our last inspection the provider breached Regulation 9 of the Health and Social Care Act, Person Centred Care. This was because people who lived on the first floor dementia unit had little engagement with staff and limited opportunities to be involved in activities that reflected their interests and hobbies. During this visit we found some improvements had been made, but not enough to achieve compliance of this regulation. This was because whilst some people were receiving a responsive service, a number of people with more complex needs on both floors were not receiving the responsive service they needed. Care records often provided just adequate information about people, and some information was difficult to read.

At our last inspection the provider breached Regulation 12 of the Health and Social Care Act; Safe care and treatment. This was because medicines on the Intermediate Care Unit were not always managed safely and risks to people's health and welfare had not always been appropriately assessed. Prior to our visit we had been informed there were concerns with medicine management on the intermediate care unit. This was particularly around the management of medicines for people newly admitted to the home and nursing staff ensuring that people received the correct medicines when their prescription had changed. At the time of our visit this had started to improve, but there continued to be issues. We found some improvements in the areas of risk management identified at our last inspection, but during this inspection we found that people's risks had still not always been appropriately identified or acted on. This meant the provider continued to be in breach of the regulation.

At our last inspection the provider breached Regulation 18 of the Health and Social Care Act; Staffing. This was because nursing staff on the Intermediate Care Unit did not have time to undertake their roles and responsibilities systematically and safely. There were not enough care workers deployed on the first floor to ensure people's safety without restricting their freedom or independence. During this visit we found there was enough time provided for nursing staff to undertaken their roles safely, but since our last visit there had been a high level of staff leave the home, and the provider had used agency nurses to cover the rota. This meant people had not always received continuity of care. We found on the first floor dementia unit, people were not having their freedom restricted as we had previously seen; but the level of staff or staff deployment meant not all people on the floor had their complex needs supported well. This meant the home continued to be in breach of the regulation.

After our inspection visit we were informed that both the registered manager and clinical lead for the ICU had resigned. This meant the home was being managed on an interim basis by the senior management team. The ongoing breaches of the Regulations, and the shortfalls in some of the service checks meant the provider was in breach of Regulation 17 of the Health and Social Care Act; Good Governance. This is the second time the home has been rated as requires improvement.

Staff had received enough training to meet people's personal care needs and most had undertaken training in dementia care, although not all had undertaken specialised dementia care training. Where staff had received training, they did not always have time to put their training into practice. Staff had not received training in' end of life care', yet supported people and their family members during this time.

The provider supported staff with training on the Mental Capacity Act; and had submitted Deprivation of Liberty safeguards where people's liberty was restricted and they did not have capacity to consent to restrictions. Staff understood the importance of gaining people's consent when undertaking care tasks to support their well-being. However, some capacity assessments were not accurate.

Staff tried to be kind and caring to people. On the intermediate care unit, people did not stay long periods of time and received support from NHS staff as well as the provider's care and nursing staff to meet their needs. However, on the other side of the ground floor and on the first floor dementia unit, people's care was provided by the provider's staff or agency staff only. People and relatives told us that whilst staff were kind and caring, they often did not have time to do anything other than personal care. All staff supported people with their dignity and privacy. Visitors were welcome at the home.

The provider had a complaints policy and procedure and actively addressed any complaints they were made aware of. Verbal concerns and written complaints had previously been looked at separately; but the provider was merging the two into one reporting tool so they could identify more effectively emerging themes or trends.

The menu for the home offered people a choice of meal each day. People with dementia were seen being offered two choices in a way they could understand. People enjoyed their meals. The home catered for people with specific diets and nutritional needs and some concerns had been raised that staff did not always attend to these.

Checks were carried out prior to staff working at the home to reduce the risk of employing staff unsuitable to work at Ardenlea Court. Staff understood how to safeguard people from abuse, and were aware of the provider's policy and procedure to report any concerns.

Premises and equipment were safe for people to use. The home was mostly clean and staff understood the importance of infection control.

People were supported to access other healthcare services when they needed medical attention.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There was a lack of continuity in nursing staff because most were agency nurses, and staffing levels or deployment on the dementia unit meant people did not receive care that made them feel safe. Medicines had not been managed well, but this was beginning to improve. Risk assessments did not always provide accurate information and written information was sometimes difficult to read. The provider's recruitment process checked staff were suitable to work in care and staff understood the provider's policy and procedure to safeguard people from harm. There were good systems to ensure the safety of premises and equipment; and the home was mostly clean.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received training to support people's personal care needs well, but people with complex dementia care needs did not get the specialised care they required. Deprivation of Liberty Safeguards, were in place for people whose freedom was limited and who lacked capacity to give consent to these limitations. Staff checked people gave consent before undertaking tasks on people's behalf. Some mental capacity assessments did not accurately reflect people's ability to make their own decisions. People enjoyed their meals, but there were concerns that some people on specific food and fluid regimes did not get the food and fluids they needed. People received other healthcare support when needed, and there was good liaison between the home and other healthcare providers.

Is the service caring?

Requires Improvement

The service was mostly caring.

Staff were mostly kind and caring but did not always have time to provide emotional and social support to those who really needed it. People who had capacity, were able to make day to day decisions about their care and what they wanted to do with the day, although we did not see much involvement of people in

the care planning process. People's dignity and privacy was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People who were more independent and who had capacity received a more personalised service which was responsive to their needs. Those with complex needs, particularly those living with complex dementia needs continued to not have a responsive service. The provider had systems to respond to verbal and written complaints. The provider had an 'end of life' care policy, but staff had not received training to support them with end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Changes in the management team and an increase in staff vacancies had led to a recent drop in the standards of care after a period of time when standards had improved. At the time of our inspection visit the home had a new registered manager and clinical lead for the ICU, but following our inspection both the registered manager and clinical lead resigned. The provider had put senior managers into the home to provide management support, but the home remained in a temporary state of flux until the new management team was recruited and could provide staff with continuity and stability.

Ardenlea Court 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This fully comprehensive inspection took place on 10 April 2018 and was unannounced. The inspection was undertaken by three inspectors, a specialist nursing advisor, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is a qualified health professional.

Prior to our inspection visit we contacted the local authority and clinical commissioning officers for information about the service. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority or health service. They informed us of concerns they had about the administration of medicines, staffing, and management of the service. We also looked at information the CQC had received from the public through our 'share your experience' website, and the statutory notifications received from the provider. A statutory notification is information about important events, which the provider is required to send to us by law.

During our inspection visit we talked with seven people who used the service and seven sets of relatives. We spoke with the registered manager, the clinical lead, the quality manager for the service, the maintenance worker, seven care and nursing staff, the receptionist, and six NHS staff who supported people using the intermediate care unit. We undertook a 45 minute SOFI (Short Observational Framework Inspection). A SOFI is a way of observing care to help us understand the experience of people who could not talk to us. During our visit we also spent time observing staff engagement with people.

We also looked at the care records of three people on the intermediate care unit; three people on the dementia unit; and one person on the general nursing floor. We looked at a sample of medication records on both floors, checked health and safety documentation, premises and equipment maintenance checks, quality audits, training records, staff recruitment records, staff rotas and staff dependency tools, and complaints records.

After our inspection visit we received information of concern about two people who lived at the home. We spoke by phone with the provider's regional director about these concerns and other issues that had been raised at the inspection visit.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we rated this key question as 'requires improvement' and there were two breaches of the regulations. These were a breach of Regulation 12, Safe Care and Treatment; and Regulation 18, Staffing. At this inspection we found improvements were still required and the home remained in breach of the Regulations.

At our last inspection the provider breached Regulation 12 because the management of medicines on the intermediate care unit (ICU) put people at risk. Since our last report was published we have received four notifications from the home of medicine errors. Two informed us that people had not received their medicines as prescribed. These omissions were identified in February 2018 by a visiting pharmacist and a relative, not staff who worked at the home; and two were notifications in September and October 2017 of medicine errors. The errors were by agency nurses and linked to hospital discharges to the home. None of these resulted in significant risk to the people concerned.

Commissioners of the ICU told us there had been improvements since our last inspection, in the management of medicines in the home, but when the registered manager and deputy manager left the home in December 2017, the standard of medicines management had again declined.

Concerns were related to when people were admitted to the home they did not always have the correct medication; and when medicines changed, these were not always administered in accordance with people's prescriptions. We also received a concern from a member of the public about poor management of their relation's medicines when they were admitted to the home. Their concern was the registered manager had not ensured their relation's essential medicines were at the home and ready to be administered on their relation's arrival. They also had concerns about the length of time it had taken for staff to make sure their relation received their correct medicines.

As a result of these concerns, the provider had met with the commissioners, the pharmacist and GP to improve the way staff managed people's medicines when they first arrived at the home. The provider's monthly 'home improvement audit' demonstrated the provider was aware of the need to make improvements in this area, and achieved some improvements since these concerns were initially identified. However, these improvements were very recent and the provider was not able to demonstrate the improvements were embedded into the organisational process.

We looked at the administration of medicines on both floors. We found some recording errors. We discussed this with the clinical lead who informed us they had put further checks in place to make sure any errors were identified quickly. This was so they could see whether the error was a record based one, or one which meant people had not received the right medicine at the right time. On the sample of records we viewed we did not see any errors. We were informed by the clinical lead of the ICU that they were also completing incident forms when errors occurred so these could be analysed and action or learning undertaken with staff to ensure errors did not occur again.

Whilst there had been some improvements, the management of medicines was not yet sufficiently robust to remove the breach of Regulation 12.

We looked at medicines that required extra checks and more secure storage, and found records provided an accurate account of medicines given, and the storage was secure and in-line with the provider's legal responsibilities.

At our last inspection we found there had been no assessments of people's pain to help nursing staff determine how much 'as required' pain medicines people who could not verbalise their pain might need. During this visit we found people's pain had been assessed. Medicine plans mostly informed staff of why people might need additional pain relief and the signs and symptoms to look out for. However, one of the people, whose medicines we checked on the first floor dementia unit had 'as required' medicines for pain. Nursing staff were aware of why the person might need the pain relief, but this was not written in the person's medicine plan. Nursing staff agreed to add this information.

People who lived in Ardenlea Court were assessed by staff to determine whether they might be at risk of harm or injury. At our last inspection visit we had concerns the provider had not always identified risks people had in relation to their care. During this visit, we looked at people's risk assessments to see whether they clearly identified potential hazards and how staff should respond. We found again that risk assessments did not always provide the detail required to support staff's knowledge about the person's risks and how to minimise them.

The risk assessments on the ICU were clinically driven and covered the basic risks related to people's clinical needs. The records written by the BUPA nurses or agency staff was sometimes difficult to read or decipher which could put people at risk if interpreted incorrectly. The written recording by external NHS staff who visited people on the unit improved the overall picture and helped the reader understand what the person's clinical needs were. The new clinical lead was aware of these issues and had started working to improve this.

On the first floor dementia unit we found risk assessments did not always provide staff with accurate and easily accessible information about people's needs. For example, for one person who had type 2 diabetes, the risk assessment informed us, 'for signs and symptoms of hypo and hyper refer to NICE guidance on diabetes.' And the same person's record when discussing the additional care plan for their medication said, 'refer to BNF 17'. This meant not only did the record not give information about what a 'hypo' and 'hyper' was and what action to take; it also expected staff to then find the documents referred to, to look for guidance. This meant that by the time staff had sourced the information, the person could be seriously unwell.

Some people's care plans did not accurately reflect risks to their health and wellbeing. We saw one person who used a walking frame, walked without staff assistance from their bedroom to the dining room. Staff knew the person did not require assistance from them to move, but the person's safe handling care plan incorrectly documented the person required a 'full hoist' and two staff to assist them to move. Another person was allergic to nuts. There was nothing in the person's care plan to inform staff that the person should not eat nuts; or, and what to do to keep the person safe in the event of them being exposed to nuts. This is of particular risk given the high number of agency staff at the home that would not be as familiar with people's individual care needs.

This meant the provider continued to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Safe Care and Treatment.

We looked at additional records for people who needed their 'blood sugar' levels monitored, and people who had pain relief patches applied directly to their skin. Records demonstrated staff were managing these safely.

At our last inspection the provider breached Regulation 18 because there were not enough staff on the ICU to support people with safe care. During this visit we found there were enough staff on the intermediate care unit but the majority of nursing staff was provided by nursing agencies. This was because the provider did not have enough of their own nursing staff to cover the rota. We looked at the staff rota for 26-29 March 2018. We found during this period, 11 different agency nurses had been used from two different agencies. At night time; of the 14 nursing shifts, nine were worked by agency nurses. This was because a number of staff had left their employment at the home in the last few months, and the provider was in the process of recruiting new staff to fill the vacancies.

The registered manager told us that whilst they had gone through a challenging period, they felt the staffing situation was beginning to improve as new care staff had been appointed. They said they were still struggling to recruit permanent nurses, but were trying to 'block book' agency nurses to provide people with a degree of continuity of nursing care. They acknowledged in practice this did not always work.

Care staff on the intermediate unit thought the staffing situation was improving. One told us that when the previous manager left, other staff also left or 'phoned in sick'. They went on to say there were now five to six new care workers and things were "Really getting better." A newer member of staff told us they felt there were enough care staff to support people. They said it would be better if the nurses were all BUPA nurses, but said the majority of the agency nurses were 'brilliant'. We noted that sickness levels had been identified as an area for improvement by the provider who had started to manage staff sickness more robustly. However, a relative felt the high level of agency staff still impacted on the quality of care at certain times and told us, "The staff change a lot, lots of agency staff on at weekends, and it's not so good."

A new clinical lead had started work at the home, but had only been in post for four weeks at the time of our visit. The clinical lead had started to make changes and drive improvements; however after our inspection visit we were informed the clinical lead had resigned.

At our last inspection we had concerns there were not enough staff on the first floor dementia unit to support people move safely around the home. During this visit, we found staff were often not visible, but we did not see people's freedom of movement being restricted. At our last visit the deployment of staff meant that people did not have sufficient staff support to encourage or give them time to eat at their own pace. During this visit, we found the lunchtime experience had improved because staff sat next to people and took their time encouraging them to eat.

Whilst there had been improvements in some areas since our last inspection visit, we continued to have concerns about staffing on the first floor dementia unit. During the day we heard two people calling out for help. Mostly their cries were not responded to because staff were not available to hear them. We had to alert staff to both people's distress. One of the people told us, "Don't leave me, I don't like it, nobody comes, I'm frightened, I want to go home." During this time we checked whether the person had a call bell they could press to alert staff to their needs. They did not have one in their room. We asked the nurse on duty why the person did not have a call bell. They told us the person would not be able to use one, but their care plan stated they could. Later that day we found one had been placed in their bedroom. The person told us, "I'm not daft; I know I press that bell to get the nurse."

We had mixed views from people and relatives of those who lived on the dementia unit as to whether they

felt safe. Some said they felt safe with comments such as, "I feel safe and at ease, the staff are nice and have a good attitude" and, "She has had a series of falls before; the family feels that she is safe here." Whereas other people and relatives told us, "I don't feel safe here; residents wander in and out of your room. It does not make me feel safe. Staff do not notice or come and remove them" and, "I don't see much staff."

We discussed our concerns about staffing with the provider. They told us the number of staff for the dementia unit was in excess of their calculation of people's identified needs. They provided us with the breakdown of nursing and care hours for each person who lived at the home. This showed that on average the care and nursing breakdown for each person was one hour of nursing care and three hours of care worker support for a 24 hour period. The provider then added 15 percent more hours to the total to give staff more flexibility.

Staff on the unit told us, "It is really busy up here." In response to not supporting one of the people who cried out, they said, "We hear them calling out but we are busy helping other people so can't always get to them quickly." Another said, "There are five of us today, sometimes there are six which makes things a bit easier." We were told that sometimes there was only one nurse on the dementia unit when there should have been two. A third said, "If I am honest, I don't think there are enough of us. We try; we work together as a team to do our best."

Despite the provider's re-assurance about there being enough staff on the dementia unit to keep people safe, from our observations on the day, we were not assured there were always enough staff available to support people at the times they needed.

On the ground floor, there were a few rooms for people who required general nursing care or end of life care. The people in these rooms were situated on the other side of the ground floor to those in the intermediate care beds. We did not see very much staff engagement with people in these rooms.

We spoke with one person who told us, "I don't like it, it is like a prison. I am stuck here all day doing nothing. Nobody comes to see you and nobody will take you for a walk." They went on to say, "You can buzz and buzz but they don't come."

This meant the provider continued to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014; Staffing.

The provider's recruitment procedures reduced the risks of employing staff unsuitable to work with people who lived in the home. References and Disclosure and Barring Service (DBS) checks were obtained before staff started work. The DBS checks whether people have a criminal record. A new member of staff confirmed they had to wait until all their checks had been received and looked at by the provider before they could start working at the home.

We looked at the cleanliness of the home and how staff adhered to infection control measures. A person told us, "This place is clean and respectful." We saw most areas of the home were clean and tidy, although one of the ground floor communal bathrooms was dirty throughout the day and when we undertook our medicine checks, we found the clinic floor was dusty. Staff understood the importance of infection control and we saw them using gloves and aprons appropriately to reduce the risk of transmission of infection.

Staff understood the provider's policy and procedures to safeguard people from harm. One told us they had received training to protect people from abuse. They said, "We don't tolerate abuse here. We are trained to recognise it, document and report it." They knew to report their concerns to their senior. Another member of

staff informed us of the provider's confidential 'whistle blowing' telephone line (whistleblowing is when an employee raises a concern about wrong doing in their workplace which harms or creates a risk of harm to people who use the service).They went on to tell us the number was displayed by the nurse station.

We checked the provider's systems to ensure the safety of the premises. We found the right checks had taken place to ensure water, gas, electric and fire systems were safe and well-maintained. Maintenance work was undertaken promptly, and equipment was serviced and checked routinely to make sure it was safe for people to use. However, we found a person who had been admitted to the home a few days prior to our inspection visit used oxygen in their room. There was no sign to inform visitors or remind staff that oxygen was being used. We informed the registered manager who ensured a sign was put on the door on the day of our visit.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated this key question as 'requires improvement'. The service continues to require improvements in this area.

We asked people and relatives what they thought of the skills and knowledge of staff. On the first floor, people told us, "I do think the staff know how to do their job." A relative told us, "I think the staff understand their responsibilities." On the ground floor a person told us, "The staff are approachable and seem to know their job."

Previously we found staff had not received training to provide a specialist dementia care service and this had impacted on the quality of dementia care people received. We were told by the provider that staff would receive further training to support their understanding and work with people who lived with dementia. Whilst there had been more dementia specific training rolled out to staff, and some people who lived at the home had their needs and choices met, we continued to see people with more advanced dementia, who did not receive support to achieve effective outcomes. A relative told us, "I don't think that the staff are trained to communicate with people living with dementia." The regional manager informed us they would soon be introducing another specialist dementia training programme to staff which had been devised in conjunction with a University which was highly respected for their work dementia care. They also informed us after our inspection visit that their lead nurse for dementia care had been working with staff on the dementia unit to improve care practice.

Staff spoke positively about the training they received. A member of staff on the first floor dementia unit said, "I've had dementia training with the home trainer about 12 months ago." Staff on the dementia unit told us they put their training into practice by being patient with people and giving people plenty of time and reassurance. However, on the day of our visit staff were not always available to provide reassurance to people when they needed it. Another member of staff told us about the training they had to support people with different behaviours. They said in relation to behaviours which can challenge, "We know to explain everything to people and to leave them to calm down if they're upset so we don't increase their anger and frustration." We saw staff put their training into practice when one person was upset and shouted at them. The person stopped shouting, but as soon as the staff member left the room, the person started to shout again.

As we found at our previous inspection visit, new care staff received one week's in-house BUPA induction training. This was linked to the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. The week's training was provided by a BUPA trainer. A new member of staff working on the Intermediate Unit told us they had enjoyed the induction training which included, "Everything from working the machines; assisted feeding, drinks and safeguarding."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

Previously we found inconsistencies in what the capacity assessments for people said, and what we experienced talking with people who lived on the dementia unit. During this visit we again found inconsistencies. For example, one person was recorded as not having capacity to decide what they wanted to eat. During our visit the person read out the menu to us and chose what they were going to have for their lunch. This person had also been assessed as lacking capacity to make decisions about their care. However, staff told us the person told them when they wanted a shower and what clothes they liked to wear. We saw this person making decisions throughout the day. This meant people were at risk of not making their own choices or consenting to their care and support when they were able to, as their assessed needs were not recorded correctly.

As we found before, the service had a DoLS tracker in place to show the applications they had made and whether an application had been granted by the supervisory body. It also noted when the DoLS would expire to ensure further applications were submitted. This made sure the service was undertaking its legal duties under the `Mental Capacity Act.

Staff had been trained to understand the Mental Capacity Act, and we saw staff put their training into practice. We saw staff on both floors request people's consent before undertaking any care tasks. For example, during lunch time on the ground floor we saw staff ask a person if they would mind being transferred from their wheelchair to a dining room chair to eat their meal. Staff waited until the person agreed before supporting them to move.

People told us they enjoyed the meals provided. One person said, "The food is nice, it is nutritious and we have a choice." Another said, "I have enough to eat and drink and I am never hungry." A relative told us, "I had lunch here on Saturday and it was very, very, nice." One person, on a diabetic diet told us they almost received a meal which they should not have. They said, "I was about to eat a pudding which I was given, and another staff member whisked it away and said that I can't have that."

During the meal time experience we saw people who lived with dementia being offered a choice of meals by staff showing them the meals 'plated up' so they could identify what the meals were. We also saw staff ask people if they wanted gravy, and where on their plates they wanted their gravy poured.

Where people were at risk because they did not eat or drink well; staff monitored people's food and drink intake. We looked at the records of one person on the dementia unit who had been assessed as being at risk because they had lost 3kg in weight in the previous three months. The nutritional record did not clearly reflect the amount of food consumed. The record said, 'ate all' or 'ate ¾' but this did not inform of the portion size. The record of the person's drinking was also not used effectively to support their hydration. For three of the four days we looked at, the person had drunk less than 700ml of fluid. The nurse in charge told us the target amount was between 1500-2000mls per day. Nobody had looked at the record and used the

information to alert staff of the need to try to prompt the person to drink more. The nurse told us they would remind staff to encourage the person to drink more.

The relative who contacted us after our inspection raised concerns about the food and fluids provided to their relation during the person's stay. They felt the staff were not sufficiently aware of the risks related to the person's eating and drinking, and did not provide adequate support to maintain the person's health. The regional manager had been made aware of this after our visit and told us they were looking into the concerns raised to see if there could be any lessons learned from the person's experience.

We checked a sample of food and drink charts on the ground floor intermediate unit. The ones we checked had been completed. However we found that people's weight was not being consistently monitored to identify if they were at risk of malnutrition. We were informed by a member of staff there had been, "Some weights which were being missed." We were informed this was being resolved and 'was slowly getting better."

We checked how the staff, team and services within and across organisations worked together to deliver effective care, support and treatment in the intermediate care unit. This unit comprised of not only BUPA staff but NHS staff such as physiotherapists and occupational therapists. We spoke with these staff to find out their views about the service. They told us the large turn-over of staff had impacted on the continuity of care provided by the home because of the providers need to rely on agency staff whilst recruiting new nursing staff. Despite this, they felt good work was being done and told us they had a consultant led team which included NHS nurses that could pick up any shortfalls as they arose.

The NHS team manager and the Clinical Commissioning Group Matron were also present during our visit. They worked closely with the new clinical lead for the home to improve the clinical skills of the provider's nursing staff. We were told the ground floor nursing staff were receptive to gaining new skills, and updating their skills in pressure area care, end of life care, continence care and catheterisation. One told us that in the past they felt the skill mix was wrong with too many mental health nurses employed and not enough general nurses. They believed the ICU was 'picking up' and told us, "They are very welcoming here and are trying hard to resolve their issues."

We looked at how people on the dementia unit were supported with access to healthcare services. A relative told us, "Mum sees the GP and chiropodist. If there is a problem and they must call the GP, they will contact us." We saw by looking at people's records that when people required further health care support, the right professionals were contacted. For example, one person told us they had recently developed a rash on their legs. They had been visited by their GP who had prescribed them some ointment which had cleared the rash up. They explained, "If I need the doctor, the nurses are very good at sorting out a doctor visit."

People's individual needs were met by the adaptation, design and decoration of the premises. At our last inspection the dementia unit was being refurbished and redecorated. The organisation was making it easier for people to identify where they were in the unit by having signs and symbols on the doors and different colour paints on the walls. The doors to people's bedrooms were being changed to look like front doors to help people identify them as places they lived. At this visit the proposed changes had been completed, and the unit looked more homely and supportive to people with dementia care needs.

Requires Improvement

Is the service caring?

Our findings

At our last inspection visit we saw staff were mostly kind and caring. Again, during this visit we found the same. People and relatives were mostly positive about the care provided by staff. We found the provider's own tracking system showed there were 14 positive comments about the care people had received since our last inspection visit; and the care home scored 9.6 out of 10 on a care home website.

People and relatives on the dementia unit were mostly satisfied with the care provided to them or their loved ones. Comments included, "I like all of the staff, they are kind to me, nothing is too much trouble" and, "Yes, they are very caring towards me." We had mixed views from relatives. One relative told us their relation had been at the home for a few weeks and was just settling in, but the care had been good. Another, whose relative had lived at the home for a longer time said they thought the care was generally good, but the changes in nurses was not always helpful and said, "The dementia care was not always well considered." A third was very unhappy with the care provided and said, "I wouldn't pay for it." They went on to say that one of the nurses treated their relation like a child and they did not feel the nurse was gentle with their relation. We spoke with the registered manager about this person's concerns. After our visit, the regional manager informed us the registered manager had met with the nurse and undertaken 'reflective practice' (looking back on the actions taken and how they can be learned from to improve).

We saw mostly when staff supported people it was in a kind and caring way, however because staff were not available, people did not always get the emotional support when needed. In the morning we walked along the corridor of the dementia unit and heard a person crying out behind a closed door, "Help me, help me" because they needed the toilet. This cry was repeated often. We saw no staff available to help the person and we had to find a member of staff to let them know of the person's distress. We recorded the person cried out on 27 occasions between 10am and 3pm. Staff were not available on any of these occasions to support the person. As well as the emotional distress experienced by this person, other people close by to the person's bedroom were also getting distressed by hearing the person call out. We found this person had recently been moved to a different bedroom because nursing staff thought it would be quieter than where they previously resided. A relative of another person told us, It's upsetting for [person] and for us. The impact on how this would affect [person] hadn't been considered." The provider told us they recognised the move had not worked and they intended to move the person back to their original room.

Later we looked at the same person's care plan. Because of a specific need identified in their care plan it was important for staff to leave the door of the person's room open so the person could identify their surroundings. The care plan also stated that staff needed to introduce themselves when they entered the room to help them feel safe. As well as seeing the door closed in the morning; later in the day we saw three different members of staff go into the room without informing the person of who they were. We spoke with the nurse in charge about this who said, "[Person] knows me so I don't need to do it." Another person was seen shouting out for staff assistance, but staff were busy. We found the person crying and they told us, "I know I am old but I deserve better than this."

We spent 45 minutes in the main lounge in the dementia unit, seeing how staff engaged with people in the

room. We saw one member of staff engage well with a person doing a word search, but at the same time spoke sharply on two occasions to a person who was trying to remove some of their clothes. We recognised the staff member probably did not want the person to lose their dignity, but felt there might have been another way they could have managed the situation without speaking with them so sharply. We saw other staff came into the lounge and greeted people who were in there. Then we saw them walk off to complete care tasks or speak with each other rather than continuing to engage with people.

We asked staff what they thought of the care on the first floor. They felt they provided good care to people and said because the care staff who worked on the first floor were permanent they knew people's likes and routines. However, staff also told us that working on the dementia floor could be challenging because they did not have time to sit and chat with people. They also said they sometimes struggled to meet the needs of more complex people. Staff told us they were very fond of the people they cared for.

People who stayed in the intermediate care unit had a much shorter stay that those who lived in other parts of the home. They came from a hospital setting and were expected to stay in the intermediate care unit for approximately six weeks whilst NHS staff supported their rehabilitation to return home; or re-assessed them to move to a permanent care facility. People on this unit were positive about the care provided by both the BUPA and NHS staff. One said, "Staff have a caring attitude", and another said, "The staff are respectful when administering care to me." A relative told us, "Caring is non-stop here." During lunch time on the ICU we saw a member of staff converse with a person about the person's daughter. The member of staff had remembered from an earlier conversation where the person's daughter lived, and the person was surprised and delighted by this. They said, "How do you know that?" with the staff member saying, "You told me once."

On both floors we saw people's privacy was respected. When personal care was undertaken, people's doors were closed so others could not see the care provided. One person told us they felt their dignity was respected because they received personal care from female staff. They said, "I always get the ladies, I told them I didn't want men to help me get washed and dressed. It's the ladies that come to me." On both floors we saw staff listened to the views of people about what they did and didn't want to do, and respected people's decisions. We did not see much information in care plans about people being involved in decisions about their care.

People's relatives were made to feel welcome. Because of the higher turn-around of people on the ground floor, and because there had been more changes with the care staff and nursing group , relationships with relatives were less developed, however we saw during our visit that relatives were welcomed into the home. On the first floor, and part of the ground floor, the permanent staff group had more time to develop relationships with relatives. Relatives were encouraged to visit the home and to stay as long as they wished. We spoke with one relative who told us that they and their other relation stayed around six hours a day in the home. However, some of this was for reassurance that their relation was receiving the care they needed. Another relative told us that through choice, they came every day to support their relation to eat their meal.

Requires Improvement

Is the service responsive?

Our findings

This key question had been rated as 'requires improvement 'at the last two inspections. There was also a breach of Regulation 9 of the Health and Social Care Act (Person centred care). It continues to require improvement.

At our last inspection we saw that care records on the dementia unit did not correctly reflect the needs of people who lived at the home. During this visit we once again found that the assessments made by staff did not always relate to the person in question. In both units we also found that some care records were very individualised, centred on the needs of the person and written in collaboration with the family and the person where possible; but others provided just enough information to support staff to know the person's basic needs.

The home had recently re-introduced the concept of 'resident of the day'. This was where each day the home manager and staff would look at the specific needs of one or two people who lived at the home to make sure staff were meeting their current needs and wishes.

At our previous inspection we found that people's emotional and social needs were not well met. There was only one activity worker who was responsible for organising the activities for all people in the home, including those on the intermediate care unit. During this inspection we found there had been some improvements. Since our last inspection another activity worker had been recruited. The activity workers booked external entertainers to come to the home three times a month, and undertook activity sessions such as a 'cinema club' once a week, 'afternoon tea' and 'breakfast club'.

We saw on the dementia unit there were a group of people who were mobile and who were able to communicate their needs well. This group had established good friendships with each other and thoroughly enjoyed the activities available to them. During our visit we saw them laughing and having a great time with the activity worker and in the company of others, whilst enjoying a reminiscence session and a game of giant snakes and ladders, and skittles.

We also saw a therapy dog visit the home, and the owner and dog went to the rooms of everyone in the home who wanted to see it and stroke it. The activity workers felt they had a good selection of one to one activities to undertake with people in their rooms. This included reading newspapers, playing cards and dominoes, looking at photo albums and reminiscence sessions. One person told us that staff supported them with their hobbies. They told us staff ensured they had the paints they needed to enjoy their hobby of painting.

Care and nursing staff did not have time to sit and chat with people, or support people's social needs, and so it was left to the activity workers to provide social engagement. This was fine for people who could attend the advertised activities, but meant those who weren't able to, were reliant on one to one activities.

We looked at the engagement which took place with those who could not always join in with group

activities. The activity workers recorded each time they either engaged or attempted to engage with people. We found those with more complex needs had very little staff engagement. For example, one person's engagement record showed for the four attempts at engagement in January 2018, the person was either sleepy or refused. There were again only four tried engagements in February and three in March. This was less than once a week. Where the person engaged, this was when the member of staff read them the newspaper or they joined in gentle exercise, but there was nothing to suggest staff had explored this more in an attempt to promote more activity.

One person walked up and down the corridor during the day. The activity worker told us they would walk with them to give them exercise, but from our observations the person appeared to be able to do this on their own and did not require the support of the activity worker for exercise. On the three occasions we walked past the person they reached out to hold our hand for comfort. No staff were available to offer support. On two occasions when staff were present, we saw staff encouraged the person to go back into their bedroom for a rest. When asked about the person, a staff member told us "She is always like that, she is really unsettled." The staff member did not know why. We later found out about the person's previous employment and when we spoke with them about their previous life experience they became more engaged and settled

Another person also walked up and down the corridor. It looked like they were attempting to dust and put items away. A staff member told us the person was 'always tidying up'. We asked if this had been acted on, and whether a duster could be given to the person to provide them with some occupation. The staff member replied, "I don't know, that would be up to activities to sort out." This suggested the care staff focused on providing personal care, with any emotional or social care left to the two activity workers to manage.

This was not a person-centred approach to providing care and meant the home continued to breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Person centred care.

We looked at end of life care provided to people. The provider had an End of Life manual for staff to follow. This included information about advanced decisions (these are decisions people take which inform of their wishes about how they would like the end of their life to be supported). It also included bereavement care details and information about care during the person's last days. We looked at the training provided to staff and found staff did not receive end of life training. This was important to support staff in knowing what the provider's expectation were for end of life care, and to help staff know when a person was approaching the end of life; help them to understand how to respond to a person's end of life needs and wants; and to prepare relatives and themselves for this.

We had received information from commissioners that an 'end of life' practice development nurse had raised concerns regarding one person's pain management at the end of their life as it had not been managed as well as it should have been. A relative we spoke with after our inspection visit told us of the poor experience they had with staff after the unexpected death of their loved one. They had asked staff for advice about what they needed to do next, on hearing their relation had passed away. They told us staff did not appear to know what they should do. The regional manager agreed staff needed further training in this area.

At our last visit we looked at how responsive the home was in relation to equality, diversity and human rights; and how it promoted inclusion for people of all religions, cultures and sexuality. The registered manager told us the LGBT community (Lesbian, gay, bi-sexual and transgender) would be welcome in the home. They were aware this was an area they needed to consider further and after our visit sent information

of an audit tool they were starting to use to check the home was accessible and inclusive to all. We were informed that since then, the tool discussed at the previous inspection had been removed as BUPA decided it was not appropriate for their homes. Instead they were looking at another way of promoting inclusivity.

We looked at how complaints were managed. One relative told us the drinking vessels which were being used had teeth marks and dirt in the corners. They told us this was raised with the registered manager and the vessels were changed. Another told us they, and other relatives, had complained about a member of staff. They told us this was dealt with. However, we were contacted by a relative of a person who had been in the home for general nursing care. They told us they had informed the registered manager of concerns about their relation's care and nothing had been done to alleviate their concerns.

We were informed since our last visit there had been four written complaints and four verbal concerns raised. The complaints and concerns covered a range of issues, with no emerging theme. The regional manager told us that until recently the verbal concerns had been recorded separately to the written complaints, but this had changed in February 2018. Since then both verbal concerns and written complaints had been analysed under the same reporting tool to see if any emerging trends or themes were identified and to ensure all were carefully considered to learn lessons from.

Requires Improvement

Is the service well-led?

Our findings

This key question was rated as 'requires improvement' at our last inspection visit. During this inspection we continued to find improvements required.

When we last inspected the home in May 2017, the registered manager had only recently returned to the home after a period of absence This had led to some of the managerial functions not being completed as well as they had been done previously. The registered manager was on a phased return to work at the time of our visit, and a newly recruited deputy had just started and was supporting the manager in making the improvements.

Commissioners we spoke with prior to this inspection told us they had seen the home improve up until December 2017 and were satisfied with the care provided.

Since December 2017, there had been a further change in management. The registered manager decided to retire and left the home in November and a new manager was recruited. This manager started work at the service in December 2017 and was registered with the CQC in February 2018.

When the previous manager left the service, a number of other staff did too. This included the deputy manager and clinical lead for the home. The new registered manager was not a qualified nurse and was reliant on their qualified deputy and clinical lead to provide support to nurses and to hold them to account. The provider informed us that whilst the registered manager was not a registered nurse, they had previous experience of managing nursing homes.

Whilst recruiting for new nursing leads, the manager from one of the provider's other local nursing homes supported the service, as well as their senior management team. However, the lack of continuity of management impacted on the nursing care provided, and this coupled with a high number of agency nurses meant that the quality of care slipped and concerns were raised by commissioners of the service about the standards of nursing care in the home.

During our visit, we found some improvements had started to be made. A clinical lead had been appointed to support the nursing staff and had been working at the home for four weeks. We found they had made a good start to supporting the nurses and improving the quality of nursing care on the Intermediate Care Unit. The provider also told us they had recruited a person to the role of deputy manager and they hoped this person would start as soon as their clearances had come through. Nurses told us they felt supported by the clinical lead. One said, "[Clinical lead] is doing a good job, trying to get everything sorted out."

The registered manager told us that whilst they had been working at the home since the middle of December, they were still becoming familiar with the provider's processes and were not yet fully confident or knowledgeable about how they worked. They were also not familiar with all the people who lived in the home. They told us they were getting good support from the provider to understand these processes and hoped to have a clear understanding of them soon.

However, this meant some of the audits and checks we would have expected to be completed had not been. For example, the accident and incident audit was not fully completed. We found six incidents had been logged onto the provider's system but there were 16 in the paper file waiting to be logged. Four incidents which had occurred in April 2018 had not yet been reviewed by the manager at the time of our visit. The regional manager acknowledged this and informed us their internal reviews had identified some shortfalls that they were working to improve.

Prior to our visit we looked at the statutory notifications sent to us by the provider. Whilst the notifications for medication errors was concerning, the level of notifications for other serious injury, and unexpected deaths was within an expected range of this type of care home.

However, after our inspection visit we were informed by a family member of the unexpected death of their relation. The notification we received about this person's death provided minimal information about the person's death and came to us five days after the person died. The provider is required to notify us of deaths within a 24 hour period. We spoke with the regional manager about this. They told us the person had fallen and had been admitted to hospital, but we did not receive information about the admission. We were informed that safeguarding authorities had been alerted to this incident by the person's family. At the time of writing no decision had been taken as to whether the safeguarding authorities were going to investigate this alert.

The regional manager also explained to us that since our inspection they had noted we had not received all the notifications we should have had, and were in the process of rectifying this.

After our inspection visit we spoke with the regional manager. They informed us the registered manager had resigned and they were in the process of recruiting a new manager. They told us they and another BUPA senior manager were providing management cover at the home until they had recruited a new manager. Both of them were registered nurses and could provide support to the clinical lead and nursing team. They said this time their preference would be to recruit a clinical manager into the vacancy.

After our discussion with the regional manager, we were informed by commissioners of the service that as well as the registered manager resigning; the clinical lead had also resigned from the service. This gave us further cause for concern because the clinical lead had driven the improvements seen on the ICU.

The continued breaches of the Regulations meant the provider had not identified or acted sufficiently to improve the outcomes for people. This meant the provider was in breach of Regulation 17 of the Health and Social Care Act (2008) Regulated Activities 2014.

We asked people if they had met the manager. Two of the three people we asked did not know who the manager was, but a relative told us, "The manager floats in and out now and then. She is approachable." Another told us they felt the hygiene in the home had improved since the manager had been appointed and care had been a 'bit more specific' to their relation's condition.

Staff told us they had regular team meetings with the management team. They said these meetings gave them the opportunity to discuss any issues of concern and areas for self and home development. One staff member told us, "Meetings are really positive. We all get on well and have a really good relationship, so you feel you can talk about anything." We looked at the staff meeting notes for February 2018. We saw a range of issues were discussed including rota management, making the dining rooms more homely for people, and ensuring records of those admitted on the ICU were completed within 72 hours of admission.

The home had a 'Home Improvement Plan' (HIP). We looked at the latest plan at the time of our inspection visit, and one undertaken two days after our visit. The HIP was colour coded, with the colour green denoting identified actions were completed, the colour amber denoting that further actions were needed; and red, denoting actions known but were yet to start. Some of the concerns we had identified had been reflected in the plan and the provider was working towards improvements. For example, some of the medication concerns had been identified and actions were being taken to improve recording, identify errors quickly, and act accordingly if mistakes had been made. However information regarding stimulating and meaningful activity provision for people was rated as 'green' and was identified as having improved. Whilst this was reflective of the activities provided to people with lower dependencies, it was not reflective of activity provision for those with more advanced dementia.

The provider had a legal requirement to inform the public of the home's rating. They had informed the public on their website they had previously been rated as 'Requires Improvement' overall; and a poster with their ratings was displayed near the lift in the reception area of the home. This meant that those who used the ICU may not have the opportunity to see the previous inspection rating of the home. We spoke by phone with the regional manager about this after our inspection visit. They informed us their own internal audit had identified the poster should be moved to a more conspicuous location and this had already been undertaken.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not always involved people or the person acting on their behalf in assessments of their care needs. Not all people's care and treatment was designed to make sure all their needs; including emotional and social needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always have their medicines available to prevent the risks associated with medicines that are not administered as prescribed. Staff responsible for the management and administration of medicines did not always administer medicines according to the prescription and record the administration of medicines accurately. Risk assessments were not always accurate and up to date. They did not always include plans for managing risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes did not sufficiently mitigate the risks related to the high levels of use of agency staff; medicine management; records management; or improve person centred care since our last visit.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure they could always meet people's care and treatment needs.