Miss Melvenia Davidson

St David's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We inspected the home on the 15 and 20 October 2014 unannounced. St David's Nursing Home is registered to provide accommodation for people who require nursing and personal care. The home provides care for up to 23 older people, some of whom are living with dementia. They also provided end of life care. At the time of our inspection St David's Nursing Home supported 15 people.

At the time of our visit there was 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 2008 and associated Regulations about how the service is run.' However the registered manager was not living in this country and the manager in day to day charge left the service in September 2014. There was no clear management structure in place.

People's safety was at risk in a number of areas. Risk assessments were not all accurately completed and for

Summary of findings

one person there were none in place. We found that pressure relieving equipment had not been correctly set and therefore did not protecting people at risk from pressure damage.

Procedures for unforeseeable emergencies including evacuation were incomplete and had not ensured individual people's safety. The on call emergency contact list (the person to take responsibility and offer support to staff) was not up to date and contained only the registered manager's number overseas.

The service had not taken into account people's ability to make decisions for themselves. Staff were not following the requirements of the Mental Capacity Act 2005. Nor had they taken action to review the service with regards to the Deprivation of Liberty Safeguards for people whose liberty may be being restricted.

We found that people's health care needs were assessed. However, people's care was not planned or delivered consistently or monitored. In some cases, this either put people at risk or meant they were did not have their individual care needs met. People were not always supported to eat and drink enough to meet their needs.

All the people we spoke with were very complimentary about the caring nature of the staff. They also told us that staff treated them with kindness and respect. However we saw that care was mainly based around completing tasks and did not take account of people's preferences.

We were concerned that some very frail people living at the home have felt isolated as there were not enough meaningful activities for people either as a group or individually.

People told us contradictory things about the service they received. While some people were very happy, others were not. In addition, our own observations and the records we looked at did not always match the positive descriptions some people had given us.

Staff training was difficult to track due to staff changes and a lack of an up to date training programme. We also saw evidence that the learning had not always been put into practice. The provider did not have a system to assess staffing levels and make changes when people's needs changed. This meant they could not be sure that there were enough qualified staff to meet people's needs. Furthermore, people and visitors raised concerns about the low number of staff.

The process for monitoring the quality of care was not effective. The process had not picked up on the concerns we found during our visit, so had not led to the necessary improvements.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

St David's Nursing Home was not safe. People were put at risk because equipment was not maintained properly or set at the correct settings.

People's risk assessments that informed safe care delivery were not always up to date or in place to guide staff.

There were not enough suitably experienced or qualified staff on duty to meet people's needs consistently and safely. However, staff knew how to recognise and respond to abuse correctly.

The provider had appropriate arrangements in place for the safe management of medicines.

Is the service effective?

Inadequate

St David's nursing Home was not effective. We found staff were not consistently following the care plans to ensure that people's health needs were met. Whilst staff had had some training and supervision, it had not always been put into practice.

Where a need had been identified to support or prevent pressure sores the staff had not adequately monitored skin conditions, nor involved the appropriate healthcare professionals promptly. Staff had not ensured the pressure relieving equipment was set to the correct settings to promote effective care.

People told us they felt involved in how their care was given, and that staff understood who they were and what they liked.

Is the service caring?

Requires Improvement

St David's nursing Home was not consistently caring. People were positive about the care they received, but this was not supported by some of our observations.

Care mainly focused on getting the job done and did not take account of people's individual preferences and did not always respect their dignity. People who were quiet and on continuous bed rest received very little attention.

People told us that they could have friends and relatives visit whenever they wanted. They also told us they could have privacy if they wished.

People felt that staff treated them with dignity and respect.

Summary of findings

Is the service responsive?

Inadequate 

St David's Nursing Home was not responsive to people's needs. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care

The manager managed complaints that had been raised. However, not everyone knew how to make a complaint or raise a concern.

Whilst people told us that they were able to make everyday choices, we did not see this happening during our inspections.

There were not enough meaningful activities for people to participate in to meet their social needs. Some people who lived at the home felt isolated.

Is the service well-led?

Inadequate 

St David's Nursing Home was not well led. The management structure of the home was not clear and impacted on the care delivery.

There were no clear lines of accountability at this time. The appointed manager had left and the registered manager lives overseas. We had not been provided with an interim management structure that ensured the people were protected.

People were put at risk because systems for monitoring quality were not effective and acted on. In addition, there was no system used to assess staffing levels against people's needs, this meant there were not enough staff on duty to meet people's needs.

St David's Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on the 15 and 20 October 2014 and was unannounced. We spoke with seven people who lived at St David's Nursing Home, three relatives, four registered nurses, five care staff, and the cook. We observed care and support in communal areas and also looked at the kitchen and 13 people's bedrooms. We reviewed a range of records about people's care and how the home was managed. These included the care plans for seven people, the staff training and induction records for all staff employed at the home, seven people's medication records and the quality assurance audits that were available. Not everyone we met was able to tell us their experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

The inspection team consisted of three inspectors. Before the inspection the provider was sent 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. Before our inspection, we reviewed the information included in the PIR along with information we held about the home. This included notifications of deaths, incidents and accidents that the provider is required to send us by law. We contacted the commissioners of the service and two healthcare professionals from the local GP surgery. We also had feedback from a tissue viability nurse and a dietician.

Inadequate

Is the service safe?

Our findings

Four people we spent time with told us they felt safe living at the home. Their comments included, "Very safe dear, there's always someone looking after us." "It's good, I'm looked after," and "I would talk to the nurse if I had a worry." One person showed us a thumbs up sign as response to our questions. However, one person said, "Lots of changes, I worry I don't know who to talk to."

Whilst each person's care plan had a number of completed health risk assessments not all assessments were up to date or reviewed regularly. This meant staff had not always worked to the most up to date information about a person.

On the second day of the inspection, one person with very high needs had been admitted as an emergency on 16 October 2014. Only one risk assessment had been completed. This was for skin integrity and the assessment was inaccurate. We queried the information recorded on the assessment with the nurse on duty, who said the information was wrong and the correct score was double the initial score. This would change the care delivery required. We looked at the pressure relieving mattress setting and found it was set far too high to reflect the person's body weight as instructed by the manufacturer. The lack of health and environmental risk assessments put the person at risk from unsafe treatment and possible pressure sores.

Information from Social Services assessment team stated this person required a pureed diet and thickened fluids to keep them safe. However there was no documentation in place to guide staff as to how to ensure food and drink were a safe and correct consistency. This placed the person at risk from choking and aspiration. This person also needed, a daily minimum of 1000 mls to drink but the fluid charts showed that for two days only 300 mls and 500 mls had been drunk. This meant that the person was at risk from dehydration. These issues were a breach of Regulation 9 of the Health and Social Care Act 2008.

There were procedures and policies in place to protect people in the event of an unforeseeable emergency. However people did not have a personal emergency evacuation plan in place. The main evacuation procedure did not contain a plan to ensure the safety of the people unable to move independently, or reflect the number of staff needed on duty to ensure people's safety. The level of staff working in the home would not ensure a safe emergency evacuation at this time due to people living over three floors and the high needs of the people living at St David's Nursing Home. Staff were unsure of the evacuation procedures. The out of hours emergency on call system had not been updated to reflect the resignation of the day to day manager and were inaccurate. Staff told us they would ring the provider who was the registered manager in America if there was an emergency. However the registered manager's registration with the Nursing and Midwifery Council had lapsed 12 months ago and therefore she would not be able to make clinical or nursing decisions. We asked for it to be updated immediately to provide staff a support system should it be required. This had not been done and remained inaccurate on the second day of our inspection. This was a breach of Regulation 9 of the Health and Social Care Act 2008.

We observed that the morning schedule was busy and staff worked hard to ensure that basic care was delivered. People that wanted to sit in the communal areas were brought down before lunch, the last person just arrived before lunch was served. We also saw that as care staff were busy, the activity person sat and offered company and support to the person receiving end of life care situated on the top floor of the building. This meant that one to one sessions scheduled for other people could not take place. There were long periods of time when people in the communal areas were left unsupervised without access to a call bell. One person had to call out for help as they had slipped down in their chair. One person told us, "I never see anybody unless it's to wash me or feed me." Another said, "They try their best, but staff keep leaving and then new staff have to get to know me and I don't always get moved gently."

Staffing levels confirmed that the actual numbers of staff working were the same as the staffing rota. All the people at the time of the inspection had been assessed as having medium to high dependency levels. This meant that they needed two staff members to undertake care and to assist them in moving, drinking and other activities of life. One person was also receiving end of life care. There were not enough staff on duty to meet peoples individual needs safely.

During the afternoon we observed that the staffing levels did not allow for staff to discretely support people in the lounge or those who remained in their bedroom. The

Inadequate

Is the service safe?

person who was nearing the end of their life spent long periods of time without the company or comfort of staff. We also saw that the cook had not arrived to prepare supper for people and one member of care staff took over the supper preparation of soup and bread. This meant that one care staff was looking after all 15 people over three floors whilst the RN administered medication, answered the telephones, door and dealt with visitors to the home. The staff could not ensure peoples comfort and safety with those levels of staffing.

Staff said that staffing levels had dropped recently as they only had 15 residents. One staff member said, “We need more staff especially in the afternoon, we can’t be everywhere. “ Another staff member said, “We did have three staff in the afternoon but when we went to 15 residents we were told to reduce staff hours, but it’s hard work and we can’t look after everyone properly and safely.” The provider did not have a system to assess staffing levels and make changes when people’s needs changed.

The staff training plan did not show that all staff had received the training or refreshers necessary to meet the needs of the people currently living in the home safely. Some staff were in need of updating their infection control training, moving and handling and food hygiene. Staff told us they were unsure of when specific training had been undertaken, but were sure they had had some. The staff files we looked at could not confirm staff training. The lack of training in safe moving and handling and in undertaking risk assessments placed people at risk from inappropriate treatment. These issues were a breach of Regulation 22 of the Health and Social Care Act 2008.

The provider had appropriate arrangements in place for the safe management of medicines. There were records of medicines received, disposed of, and administered. Nurses who administered medicines carried out the necessary checks before giving them and ensured that the person took the medication before signing the medication administration record (MAR) chart. We looked at nine people’s MAR charts and found that the recording was accurate and clear. Staff told us that people were currently taking their medication as prescribed. Skin creams were recorded by care staff on a separate recording sheet. This assured us that the records showed people were given their medicines as prescribed. Medicine administration audits were conducted on a monthly basis and we saw that any anomalies recorded were followed up by senior staff, such as when staff signatures were missing.

Staff told us they were aware of the need to consult a GP if a person continued to refuse their medication. This was to ensure that the impact to their health of not taking the medication was passed on to the prescribing doctor.

We could not confirm that all staff working at St David’s Nursing Home had completed safeguarding adults at risk training due to the lack of training records. However we spoke with Staff who were able to tell us how they would respond to allegations or incidents of abuse, and also knew the lines of reporting in the organisation. In addition, we saw evidence that the day to day manager had notified the local authority, and us, of safeguarding incidents before her resignation. People told us they felt safe living at St David’s and did not have any concerns about abuse or bullying from staff. The relatives also said that they were not concerned about their loved ones’ safety at the home.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work, that the provider obtained references and carried out a criminal records check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by St David’s Nursing Home and bank nurses all had registration with the nursing midwifery council (NMC) which was up to date

Inadequate

Is the service effective?

Our findings

People told us, “They look after us well, we know that they will help us and the doctor comes to see us regularly.” Another person told us, “I would like more information but not all staff know what is going on.”

We were told there was one person with a pressure sore living at St David’s Nursing Home. We saw that the pressure sore had been recorded and photographed, however there was some confusion of the wound healing status documented by different registered nurses. This meant that staff we spoke with were unclear how serious the wound was, and if the person was receiving appropriate care to deal with the severity of the wound. We also found that this person’s pressure mattress was on a too high setting for the person’s weight which could cause further skin damage.

We looked at all 15 people’s pressure relieving mattress settings against people’s weight and their personal health risk assessment. We found that the mattress for one person who was on continuous bed rest, had fully deflated and was not providing any pressure relief. We reported this to the nurse on duty. Following investigation by the maintenance person we were told there was an electrical fault. Pressure mattress settings for 13 people were incorrect. Some mattresses were set at twice the setting recommended for the person’s weight. We asked that all mattresses were checked to ensure people’s skin integrity was not at risk from the incorrect setting. On our second day we looked at the settings again and found that nine were incorrect. We asked why the settings were still incorrect and were told that some were not working properly, so staff had set them at a high setting in case they deflated. This was referred to the local authority safeguarding team for investigation. This was a breach of Regulation 9 of the Health and Social Care Act 2008.

We raised some concerns with staff about wound care management and the monitoring of one person’s wound as there was conflicting information recorded. Due to a lack of full time registered nurses there was a lack of consistent treatment. One record stated there was improvement to the wound where the next entry stated deterioration. We were told that staff had had advice from the tissue viability nurse in the past, but would contact them for further advice. We saw a person had pressure wounds. This was documented on a body map but there was no documentation or care plan that stated the treatment and care required to promote healing. There was also no guidance or risk assessment in place to guide staff in moving this person safely whilst attending to their personal care. During our inspection we noted a further dressing that had not been recorded on the body map or in a care plan for wounds. Staff had not completed an accident record or investigated how the wound had happened. The nurse in charge was not aware of this new wound. The provider did not have an effective system in place for ensuring the safety and welfare of people who used the service. This was a breach of Regulation 9 of the Health and Social Care Act 2008.

All of the people living at St David’s had bed rails in place; this was because of the type of nursing profile bed used in the home. Under the Mental Capacity Act (MCA) 2005 Code of Practice, the use of bed rails could be seen as restraint. Bed rail risk assessments were in place for all people where bed rails were used. Some people had consented to the use of bed rails and we saw that the risk assessment was signed to indicate their consent. For people who could not consent to the use of bed rails, the home had not completed a full mental capacity assessment. This should be undertaken to ascertain if the person could consent to the restriction of their freedom (bed rails). If not, it must be explained why the bed rails were used in their best interest and if other options had been explored. This meant that the home could not demonstrate that bed rails were used in some people’s best interest and in line with legal requirements. We observed that people in bed did not get respite from the bed rails even whilst being assisted to eat. We saw that in some cases, families had been approached for consenting to care decisions but they were not the enduring power of attorney and therefore not able to make health care decisions on behalf of their family member. We asked staff of their understanding of the MCA and found staff were not clear and did not know how to refer people to DoLS. This was a breach of Regulation 18 of the Health and Social Care Act 2008.

We saw that do not attempt resuscitation (DNAR) forms had been completed for people and that they had been completed in line with current guidelines.

Three people felt that they had enough to eat and drink during the day and night. One person told us, “I never feel hungry at night, but I can ask for a cup of something if I fancy it.” They went on to say, “We don’t get a choice of food, but it’s always tasty.” A relative told us, “The food

looks fine, but it's fairly basic." We asked the relative about the amount of food and drink on offer and they said, "There are drinks at 11ish and again at lunch and teatime, my relative can't drink on their own so staff have to come and help, my relative's weight does seem to be low at present, but staff have reassured us he? does eat well." Another relative told us, "I think the food is okay, would like to see cakes in the afternoon instead of biscuits but overall I think they get enough food." We saw staff update fluid and food charts after the evening meal. However the daily total eaten and drunk by each person was not effectively monitored or followed up by staff. We saw that one person had not received enough to drink in a 24 hour period when it stated on the care directives from social services that this person suffered from excessive thirst. Another person was unwell and had only 500 mls on the 14 October. Staff had not ensured that some/all/these two people had received the necessary amount of food and drink to keep them healthy.

Special diets had been provided. For example some people were on a soft or pureed diet due to problems with swallowing. However the pureed food we saw was not attractively presented in separate portions so that the person was able to taste each individual item that made up the meal. We saw that one staff member mixed the food up before assisting the person with the meal. This meant that the person would not be able to distinguish different tastes. We also noted that two people were assisted in bed with their meal whilst the staff member stood over them without lowering the bed rails. This had not ensured eye contact was made and that the staff member could not tell the person had finished each mouthful before being given the next.

People in the communal area were not offered the opportunity to sit at the main dining table in the conservatory. Staff had not thought to offer this facility and when we asked people about eating at the dining table, they said, "Thought it was only for staff in there" and "It's only used at Christmas." People remained in the lounge eating from a small table with the television on. No condiments were offered. There was little talking or interaction seen throughout lunch and it was a solitary experience for people. We saw that one person had a plate guard but no special cutlery was available to encourage independence.

We were told food was available throughout the day, but we noted there was no easy access to fruit or drinks. We also noticed that the timings of the lunch, tea and evening meal were quite close together. Lunch was served at approximately 12:30pm, with afternoon tea about 3pm. The evening meal was then served at 5:15 pm. No one had any complaints about the timings of the meals but on the day of the inspection the evening meal was just soup and a slice of bread, and then nothing until breakfast the next day. There had been no thought of looking at who had not eaten much lunch and ensuring a more nutritious supper was available. Staff had not ensured that people had had enough food and drinks to maintain their health. We saw that people's weight was monitored monthly, and there were people who had lost weight. The staff told us that fortified food was offered when weight loss was identified and that the GP and dietician informed. We saw that two people's weights indicated weight loss in September 2014 but we did not see any evidence that this was followed up by staff or referred to a dietician. This had not ensured people had the nutrition required to maintain their health. These issues were a breach of Regulation 14 Health and Social Care Act 2008.

Everyone told us that they are so good, They understand me and make sure I am well." Staff were able to describe to us how they met or understood people's individual needs or preferences, for example favourite foods, they thought staff had the skills and training to be able to meet their needs. "Very good staff here, I think medical conditions and specific care that people needed.

The staff felt that they had received good training. We saw from individual staff records that training had been given on topics such as infection control, dementia awareness, health and safety and prevention of falls. However due to the concerns we had about the delivery of the service, changes in staff, staff leaving and the resignation of the appointee manager we could not be assured that all staff currently working at St David's Nursing Home had received the training and support necessary to meet people's needs. This is a breach of Regulation 23 of the Health and social Care act 2008.

We saw that external health care professionals had visited the service, such as GP's, speech and language therapists, chiropodists, opticians and the tissue viability nurse. The staff recorded health professional visits in individual care plans. All of the people we spoke with were happy with the health care support they received. One person told us, "We have a chiropodist and optician, I think they come and visit

Inadequate

Is the service effective?

every so often. The dentist and GP visit as well." A relative told us, "I am sure I was told that the GP had been and there was nothing new." An example where the service was effective to people's needs was with regards to the food that they received. The chef was able to identify each person's food requirements and their preferences. They gave examples of particular foods that individuals did not like and the alternatives that they would be offered when this food was on the menu. There were clear records in the kitchen kept that detailed a people's nutritional requirements, such as thickeners in liquids to help the people swallow easier. This ensured that the chef understood each person's needs when they planned the menu and prepared the food.

Requires Improvement

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People and their relatives stated they were satisfied with the care and support they received. One person said, "The care here is very good. Nothing is too much trouble. The staff are very good." Comments from people told us time and again that staff were held in positive regard. Another person said, "Since my relative has been here their whole outlook has improved. Before, they had no energy but now they have put on weight. The staff are doing a good job. I'm pleased with them."

Two people told us that they felt that they had been involved in the planning and review of their care. A person who used the service said, "They know what I like and don't like, they are good at remembering this." A relative told us, "I don't think they understand and meet my family member's needs, I want my relative to have stimulation and not just stare at the wall." Another person told us, "I know my tablets have been changed but I'm not sure why. We looked at care documentation and could not determine whether people were involved or kept informed of changes to their treatment and medication. This is an area that requires improvement.

Throughout the day we observed that staff had not ensured people were given the opportunity to give consent for certain areas of care delivery. For example, we saw staff moved two people with an electrical hoist without asking them or explaining what they were going to do. We did see staff move one person in the lounge in a way that was respectful, by placing a screen around them and telling them what was about to happen. We also saw that before lunch staff placed clothes protectors' around peoples necks with asking or telling them what the clothes protector was for. One person was asleep in bed when they put the bib around their neck. This person was without their hearing aids and glasses which did not facilitate any communication between care staff and the person. During the lunch we saw that meals were placed in front of people without being told what it was or if it was what they wanted. These examples given demonstrated that some care delivery was undertaken without seeking peoples consent and agreement. This is an area that requires improvement.

We saw that people's differences were respected. We were able to look at all areas of the home, including peoples own bedrooms. We saw rooms held items of furniture and possessions that the person had before they entered the home and there were personal mementoes and photographs on display.

Care staff strove to provide care and support in a happy and friendly environment. We heard staff patiently explaining options to people and taking time to answer their questions. People were treated with dignity and respect in all verbal interactions. However we saw one person who wore a cardigan with another residents name on the label, which impacted on that person's dignity. When we pointed this out to a member of staff they immediately supported the individual to change the item of clothing.

People told us staff respected their privacy and treated them with dignity and respect. Staff told us how they assisted people to remain independent, they said, "A resident wants to do things for themselves for as long as possible and our job is to ensure that happens. So, for example though this resident can't manage a shower any more without support we can encourage all the skills associated with the task of washing and dressing". One member of staff told us how they were mindful of people's privacy and dignity when supporting them with personal care. They described how they were able to use a towel to assist with covering the person while providing personal care. This showed staff understood how to respect people's privacy and dignity. We saw staff use a portable screen when a person needed support with a hoist to move from their chair. We heard the person become distressed during the transfer and heard staff reassure and explain again what they were doing. Staff were observed providing care in a patient and warm manner. Staff were able to tell us about why they used the screen and were able to express ideas of protection of people's privacy and dignity.

People and their relatives felt that they were listened to respectfully and their concerns were responded to promptly. One person said, "It's like a first class hotel. I wouldn't want to live anywhere else. The foods very nice and the staff are wonderful. I wanted to be with my husband and we have a room together." We also spoke with one person who remained in bed throughout the day of our visit. They told us he had chosen to remain in bed that day and felt comfortable and supported to make that choice. They told us, "I made the choice, simple as that."

Inadequate

Is the service responsive?

Our findings

People were happy with the standard of care provided. They also told us that they felt the care met their individual needs. One person told us, "I get to be with my husband and I get to go out for a cigarette when I want one." They went onto say, "I don't mind who gives me personal care but I know I can have a choice if I want." This person was happy for us to share their views in this report. Another person said, "I suppose I'm lucky to be cared for but I get frustrated when things don't work, like my television. " A relative told us, "Things aren't as good here as they were, my relative used to get up but now stays in bed, I don't know why."

We had mixed views from visiting healthcare professionals about the responsiveness of the service. Comments included, "The staff do a good job. They recognise when there is a problem and then refer the person to us. Their assessments are satisfactory and they keep us informed." "Communication has fallen by the wayside, I have not been kept updated about the person's response to treatment and that is a worry." And "I am extremely concerned that staff are not keeping us informed as they should and people are not getting the care they need." The responses to our questions showed us that this is an area that requires improvement. These issues are being considered under a safeguarding investigation.

We asked people and their relatives if they had been involved in the assessment of their needs. Some told us that they could not remember, while others told us they had been. The care plans we looked at were well organised with an index at the front. This made it easy to find where information was in the file. The files gave information about the person's family history, their preferences, relationships, family and key medical information.

Staff told us they felt the care plans were detailed enough so that they could provide good quality care and know the person as an individual. Staff were seen to refer to people by their preferred name, and show an interest in them and what they were doing. When we reviewed the care files we noted that not all contained detail about the person and their support needs. For example one new admission did not give any instructions to staff on how best to communicate with that individual. This person could communicate but they needed time to respond and we found staff did not know that. They had presumed that this person could not verbalise their needs. We also saw that for another person that their preferences and communication care plan had been put in place on admission in 2008 and not changed to reflect the changes to their ability and health and welfare. This meant that agency staff and new staff would not be able to provide care in the way that was now required. On talking to this person's relative we found that they were really worried about the isolation and loneliness as they felt staff had not adjusted the way the care was delivered sufficiently. They said "My relative has really withdrawn since they stopped taking him into the lounge, they also forget to put on glasses and hearing aids."

Five of the seven care plans we looked at had not been regularly reviewed. We saw that one person's care plan had last been updated in August 2014 and had not reflected weight loss, skin condition, mental health status or physical health deterioration. In another we saw that despite being end of life the care plans had not been updated to reflect this change. There was no guidance in place for staff in meeting this person's very different needs, such as mouth care as they were longer able to eat or drink and being unresponsive. In another care plan we saw that the moving and handling care plan and risk assessment had not been updated to the person requiring the use of a hoist when they needed to be moved. This meant that we could not be assured that peoples changing needs were being responded to. We also received feedback from a healthcare professional who said, "The files were too general in content, providing little in the way of detail and plans for managing identified needs." We found that staff had not been responsive to people's changing needs. These issues were a breach of Regulation 9 of the Health and Social Care Act 2008.

Care and support was provided as part of a standard routine rather than based on individual preferences. Drinks were offered only at certain times and were not readily available at other times. Food was offered only at set times and not in between. No fresh fruit was available unless it was part of the meal. We were told by one person, "It's a bit like being in the army, I don't like to interrupt the routine, but you get used to it." Another said, "I would like to sometimes be able to go out but it's not fair on staff as there are not enough of them." We looked at people's individual care plans to see if people's wishes were reflected and acted on. The care plans did not reflect some people's specific need for stimulation. There were times when we saw that people were isolated and staff

Is the service responsive?

interaction was minimal due to other tasks being undertaken. An example we saw was a very frail person who was nearing their end of life. In the morning the activity co-ordinator spent time with them which meant that they were not alone, but in the afternoon staff were too busy to sit with this person. Activities were not as yet meeting people's individual interests and hobbies. The activity co-ordinator spent time on one-to-ones but this meant the people in the communal areas were left watching television with no meaningful activity. The activity co-ordinator was kind but lacked support and input from senior staff in how to approach creating activities for everyone in the home.

During the afternoon we observed that the staffing levels did not allow for staff to discretely support people in the lounge or those who remained in their bedroom. People spent long periods of time without the company or comfort of staff. We asked people, staff and visitors if they felt there were enough staff. We had a mixed response. One person told us, "I think we have just about enough staff. They come and make sure I am comfortable. I do have to wait for them to come sometimes when they are really busy." A visitor told us, "I think they could do with more staff, I am confident that the reason my relative stays in bed all the time is because it saves the staff time, but I worry about my relative is not receiving any mental stimulation." Another relative told us, "The staff are kind, but there are not enough of them."

People told us that there were activities sometimes on offer, but these did not happen very often. One person told us, "We have had a singer that came in, and we enjoyed singing along with them." However another person said they were, "As bored as could be, nothing happens just daily boredom." A relative told us, "I've never seen much going on, but they seem to watch television a lot. I have seen a staff member doing nails and talking with them though." Another relative told us "Someone did ask us what hobbies my relative enjoyed."

Whilst we saw that visitors were welcomed during the day and there were some activities on offer by the provider there was a need to give more stimulation and individual activities to people over the course of the day. This was a breach of Regulation 9 of the Health and Social Care Act 2008.

We asked people what they would do if they were unhappy with the service. They all told us they would tell the staff. One person told us, "I would tell the staff." However another person said, I don't like to make a fuss but if I had one problem it would be that I can't always get hold of anybody. That's the one gripe- if I want to see the person in charge I can't. Evidently they can't get hold of a manager but one has been appointed." A relative said, "I would talk to the staff, but I am not aware of any information pack that might tell me how to make a complaint." Another relative told us they had seen the complaint procedure on a notice board and this told them how to make a complaint.

The service had a complaints policy in place. This detailed how the service would deal with complaints. This included the timescales that the service would respond by. It also gave details of external agencies that people could complain too such as the Care Quality Commission and Local Government Ombudsman. This information was contained within the service user's guide which was available in the entrance hall. Although not all relatives we spoke with knew it was there. The staff kept a complaints log. We saw that a clear record was kept of each complaint that had been received. The service had recorded the investigation into the complaints and identified any trends, patterns and contributory factors. From looking at the records we could see that people had been responded to in good time. There had been no complaints recorded since our last inspection visit. No one that we spoke with said they had raised any formal complaints recently

People told us they felt comfortable giving feedback to the staff about their care. We asked people if they thought things improved if they raised issues with the service. One relative told us, "I would tell the senior nurse and they are very sweet and would try hard to resolve it."

At the time of our visit there had been no residents or relatives meetings held at the service for some months. These are useful because they give people an opportunity to feedback and at the same time see if other people are having the same problems, or to give positive feedback about the service.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in post who was also the provider (owner) of the service. However the registered provider was living in America and whilst in daily contact with staff was not involved in the day to day running of the service. The registered provider had employed an appointee manager to take over the registered managers' role but the appointee manager left on the 15 September 2014. We had not been informed of this change until 7 October 2014. There was a lack of management in place which reflected on the inadequate standards of care provided. The registered nurses were not experienced in management or confident enough to be left in charge of St David's Nursing Home without support of a manager. This was a breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009.

One nurse described themselves as the, "Senior nurse on duty", but did not regard themselves as the person in charge. We asked how the provider could be sure they were aware of what was going on in the home at all times. from overseas. The provider spent much of their time abroad but a member of staff told us "They phoned every day". A member of staff said, "I've seen the proprietor twice in seven months. They attended the team meetings. I can talk to them but I have not needed to. They are the kind of person who is approachable." It was difficult for us to establish that the provider had a good working knowledge of the home in the absence of a registered manager and the provider declined to speak to us by phone on the day of our inspection. This indicated the provider was not able to keep the day to day delivery of the service under review.

Staff gave different feedback about the support they received. One person told us "I don't really feel supported. I don't always get cooperation from colleagues but I will speak with the new manager when they start." Another person said, "I feel supported by the other staff and management. If there was a problem I could speak to management. I've never had a problem that couldn't be resolved." This showed us the management was regarded differently by the staff team. The staff we spoke with had no clear vision or set values. We found the culture within the staff team was unsettled and closed. One registered nurse stated they were not accountable once they had finished their shift and therefore not responsible. The lack of team work within the staff team demonstrated the service was not well-led.

We saw there was inconsistency in how the paperwork was organised and completed. For example, we looked at the daily report completed by staff and found entries for six named people on the first day, 13 people had an entry on the second and on the third day only one named person received an entry. We asked why only one person had an entry and were told, "Obviously no change to anyone else." This meant that there were no daily records completed and no information recorded for people and no audit trail that evidenced care had been delivered. The senior nurse on duty said, "There's no consistency at work. None at all and it comes done to a lack of communication. I can come into work and find that there's a builder here or like today, a window cleaner just turns up. There is an administrator for just one day and it's not enough."

We looked at quality assurance audits and found that they were disorganised and not undertaken regularly to evaluate the service provided. For example, a medication audit was undertaken in June 2014 and July 2014, infection control procedures had not been audited since June 2014 and care plans had not been audited since July 2014. The management quality assurance policy stated audits were to be undertaken monthly. We saw an action plan dated 2013 that detailed the need for monthly audits to be completed on care plans, medication, health and safety and supervision. The records we saw did not demonstrate that these had been undertaken monthly. We could not identify a system in place to identify any areas for improvement and how these could be addressed in order to meet the needs of the people living and working at the home.

We asked staff how they gathered the views of people. We were told that they spoke with people an individual one to one basis. Meetings, which could provide an opportunity for people to express their views about the service, were not held. This meant the provider missed opportunities to seek feedback from people on an on-going basis. We saw the last satisfaction survey that was held in January 2012. This demonstrated the service did not have systems in place to gather the views of people connected with the service. These issues were a breach of Regulation 10 of the Health and Social Care Act 2008.

Inadequate

Is the service well-led?

Staff meetings were held regularly. Staff told us these were opportunity to discuss any issues relating to individuals as well as general working practices. They felt the meetings provided a chance for staff to understand their individual roles and responsibilities. We heard that nursing staff held a separate meeting to discuss with the provider the departure of the manager and proposals for the recruitment of a new manager. We asked to see the records of the meeting but were unable to locate them.

Accidents and incidents were appropriately recorded and formed part of the quality assurance systems that were in place. We saw an action plan dated 2013 that detailed the need for monthly audits to be completed on care plans, medication, health and safety and supervision. The records we saw did not demonstrate that these had been undertaken monthly. We could not identify a system in place to identify any areas for improvement and how these could be addressed in order to meet the needs of the people living and working at the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of service users and others. Regulation 10.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration. Regulation 14 (1) (a) (c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. Regulation 18.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The registered person did not have suitable arrangement in place to ensure that staff received appropriate training and professional development. Regulation 23
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 CQC (Registration) Regulations 2009 Notifications – notice of absence The registered person had not informed us of the absence of the registered manager, nor told us of the arrangements put in place to manage the service during that absence. Regulation 14

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered provider had not taken steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe by means of carrying out of an assessment of needs of each service user and the planning and delivery of individual needs.** There was a lack of risk assessments in place that ensured service users were receiving safe appropriate care. **The equipment in use to protect service users from pressure damage were either not maintained properly or incorrectly set and placed service users at risk from inappropriate treatment and care. Regulation 9**

The enforcement action we took:
A warning notice has been issued. The service is to be complaint within one month of receipt of the warning notice.