Care Worldwide (Nottingham) Limited

Beechdale Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16 and 17 August 2016 and was unannounced.

Accommodation and nursing care for up to 65 people is provided in the home over three floors. The service is designed to meet the needs of older people. Some people were living with dementia. There were 52 people using the service at the time of our inspection.

At the previous inspection on 3 December 2015, we asked the provider to take action to make improvements to the area of good governance. Following the inspection the provider sent us an action plan to tell us the improvements they were going to make. During this inspection we looked to see if these improvements had been made. At this inspection we found that improvements were still required and the regulation had not been complied with.

A registered manager was in post but she was not available during the inspection and was no longer working as the manager of the home. An acting manager was in place on a temporary basis and was available during the inspection. However, no application to register a new manager had been received by the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

Potential safeguarding issues had not been reported or not reported accurately putting people at greater risk of abuse. Identified risks to people were not always managed safely and accidents and incidents were not well documented to show that they had been appropriately responded to.

Robust systems were not in place to ensure that sufficient numbers of staff were on duty to meet people's needs and keep them safe. Safe infection control and medicines practices were not always followed. However, staff were recruited through safe recruitment practices.

Not all staff received appropriate induction, training, supervision and appraisal. People's needs were not fully met by the adaptation, design and decoration of the service. People's rights were not fully protected under the Mental Capacity Act 2005.

Documentation to show that people received sufficient to eat and drink required improvement. However, external professionals were involved in people's care as appropriate.

Staff were kind and knew people well. However, there was limited evidence that people and their relatives were involved in decisions about their care and advocacy information was not available to people.

People's dignity and privacy were not always fully protected. However, we were told that staff encouraged

people to be as independent as possible.

People did not always receive care that was responsive to their needs and activities required improvement. Care records contained some information to support staff to meet people's individual needs but could be further improved.

A complaints process was in place and staff knew how to respond to complaints. However, information on how to make a complaint was not easily accessible to people.

People and their relatives had some opportunities to be involved in the development of the service; however, it was not clear that issues raised were fully responded to.

The registered manager was not working as the manager of the service. Staff views on the quality of leadership was mixed and some staff felt that they did not receive constructive feedback.

Systems in place to monitor and improve the quality of the service provided were not effective.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Potential safeguarding issues had not been reported or not reported accurately putting people at greater risk of abuse. Identified risks to people were not always managed safely and accidents and incidents were not well documented to show that they had been appropriately responded to.

Robust systems were not in place to ensure that sufficient numbers of staff were on duty to meet people's needs and keep them safe. Safe infection control and medicines practices were not always followed. However, staff were recruited through safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff received appropriate induction, training, supervision and appraisal. People's needs were not fully met by the adaptation, design and decoration of the service. People's rights were not fully protected under the Mental Capacity Act 2005.

Documentation to show that people received sufficient to eat and drink required improvement. However, external professionals were involved in people's care as appropriate.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and knew people well. However, there was limited evidence that people and their relatives were involved in decisions about their care and advocacy information was not available to people.

People's dignity and privacy were not always fully protected. However, we were told that staff encouraged people to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that was responsive to their needs and activities required improvement. Care records contained some information to support staff to meet people's individual needs but could be further improved.

A complaints process was in place and staff knew how to respond to complaints. However, information on how to make a complaint was not easily accessible to people.

Is the service well-led?

Inadequate

The service was not well-led.

People and their relatives had some opportunities to be involved in the development of the service; however, it was not clear that issues raised were fully responded to.

The registered manager was not working as the manager of the service. Staff views on the quality of leadership was mixed and some staff felt that they did not receive constructive feedback.

Systems in place to monitor and improve the quality of the service provided were not effective.

Beechdale Manor Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 17 August 2016 and was unannounced. The inspection team consisted of an inspector, 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 service.

Before our inspection, we reviewed information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service and Healthwatch Nottingham to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with seven people who used the service, five visiting relatives, the head chef, a domestic staff member, a laundry staff member, the maintenance person, three care staff, a senior care staff member, a nurse, the acting manager and a representative of the provider. We looked at the relevant parts of the care records of seven people who used the service, three staff files and other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

A potential safeguarding issue involving a physical incident between two people who used the service had not been referred to the local authority. Information relating to a different physical incident between the same two people who used the service had not been accurately referred to the local authority which could have led to a delay in appropriate guidance being received to minimise the risk of further incidents and potential abuse. This meant that potential safeguarding issues had not been responded to appropriately by staff which had put people who used the service at greater risk of abuse.

We saw that a person had developed two serious pressure ulcers. These ulcers should have been identified by staff and action taken before they had deteriorated to that state. When the ulcers were discovered a safeguarding referral should have been made to the local authority regarding possible neglect. Staff had not made a safeguarding referral. This meant that a potential safeguarding issue had not been responded to appropriately by staff which put people who used the service at greater risk of abuse. We asked the acting manager to make a safeguarding referral during our inspection.

We did not receive training figures during the visit so could not confirm that all staff had attended safeguarding adults training. We requested that this information be sent to us following our visit but the service did not send it to us. This meant that we could not be sure that effective systems were in place to ensure that all staff would have the knowledge to minimise the risk of people who used the service suffering abuse.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information on safeguarding was also not available to give guidance to people and their relatives if they had concerns about their safety. This meant that there was a greater risk that people and relatives would not know who to contact to raise safeguarding concerns if they did not want to raise them directly with staff working at the home.

People and relatives told us that they generally felt safe. A person said, "Nothing worries me [about] being here." A relative said, "[My family member] is safe now. We feel happier." However, some people raised concerns regarding other people who used the service entering their bedrooms without their permission. A person said, "I've got used to it now. But I have the odd person wandering in at night. One was tapping me on the face and frightened me to death. It happens most days." Another person said, "I feel safe but would like locks on the door. A couple of people come in by mistake in the evenings. I tell them to go and they go."

A safeguarding policy was in place and staff were aware of the signs of abuse and they told us they would report any concerns to management or to the CQC if management did not respond. The nurse told us they could make a safeguarding referral to the local safeguarding team if needed and they had previously had contact with the team on recent visits to the home. However, we found that staff did not always follow the safeguarding policy and did not always make safeguarding referrals when appropriate.

Risks were not always managed so that people were protected from avoidable harm. A person said, "I don't feel safe as I can't stand at my sink by myself and there's only one rail by the loo so I have to lean on the toilet roll holder too." A relative told us that safety measures put in place to keep their family member safe were regularly not working. They said, "I don't have peace of mind when I leave here." We raised these issues with management.

A staff member supervising one of the lounges said to one of our inspection team, "Would you mind keeping an eye if I just pop out quickly and talk to someone?" The staff member left the lounge before the inspection team member could decline. The staff member returned three minutes later. Six people who used the service were in the lounge with a hot drinks trolley at the time. This meant that people who used the service were put at risk of avoidable harm as staff did not appropriately supervise them at all times.

We saw that the premises were not always managed safely to minimise the risks to people. A trolley used to keep food warm, which had very hot surfaces to touch, was stored in a kitchen/dining area and was observed to be unsupervised by staff at times with two people who used the service in close proximity to the trolley. The plant room, containing dangerous machinery, was unlocked and allowed people who used the service access to the machinery and also to leave the home unnoticed by staff putting them at risk.

We observed that thickening agent for a person who required thickened fluids was kept in their bedroom where it was possible for people to access them. There has been a national safety notice advising how these agents should be stored to restrict access. If these products were consumed by other people they could cause harm.

Accident and incident forms were either poorly completed or not completed for some events. Accident forms completed over a week previous to our inspection had not been reviewed by a manager to ensure that appropriate action had been taken by staff. This meant that there was a greater risk that appropriate actions had not been taken by staff to minimise the risk of avoidable harm to people who use the service.

Checks of the equipment and premises were not always taking place and action was not always taken promptly when issues were identified. A person said, "It's bad that the lift is still not mended. It's five weeks now so no excuse. The paramedics had to put a lady upright in a chair the other day to get down." The lift had been repaired by the end of our inspection visit.

There had been a number of months where no maintenance staff member had been working at the home. As a result of this, the current maintenance staff member had a significant amount of work to address. They were in the process of doing this but we saw that some checks were out of date, some checks had actions outstanding or the records of checks could not be found. This included portable appliance testing, lift servicing, the nurse call system and fire risk assessment. The nurse call system check showed that the system was not working in one room but no action had been taken to ensure that the person remained safe until the system was working again. We raised this issue with management who arranged for the person to move to a room where the system was working. This meant that appropriate action was not being taken to ensure the premises and equipment remained safe for use at all times.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the records for two people who required staff support to change their position to manage their risk of suffering skin damage. Documentation was not correctly completed to evidence that this support from staff was taking place. A staff member told us that training on the use of the documentation would be

helpful as it had been changed a number of times and commented that staff on each floor did it differently. They said, "We don't know where we are with the paperwork and how it should be filled in." We discussed this with management who agreed to review documentation and training for staff to ensure that accurate records were kept of support provided by staff to minimise the risks to people of suffering skin damage.

Care records contained risk assessments advising staff what the risks to a person were and how these risks could be reduced. Risk assessments were in place although for one person most of the assessments had not been reviewed between January and July 2016. Another person's risk assessments had been reviewed monthly since April 2016 but there were gaps prior to this. This meant that there would have been a greater risk in the past that risks to people had not been promptly identified and responded to.

Two people told us that they didn't feel restricted by the way risks were managed. A person said, "I can do things like I can go down to the ground floor lounge or to use the vending machine for chocolate. My friend takes me out too." Another person said, "I'm quite free, no real restrictions." However another person felt restricted due to a lack of equipment. They said, "The hoist is broken on this floor so they have to fetch one from another floor. I was still dressed and in bed at 11.50am yesterday when my daughter arrived."

Feedback on medicines management at the service was mixed. A person said, "I'm on about 15 tablets and am not sure what they're all for. On odd times [staff] will leave them with me if I'm eating and I'll take them later. I'm supposed to have my legs creamed every day but [staff] don't always do it." Another person said, "[Medicines] are usually on time, often [staff] leave them with me on my table for me to take." A third person said, "[Staff] stay with me. I take quite a lot [of medicines]."

A relative said, "We've had no concerns with [my family member]'s medications." However, another relative said, "[My family member] has (a strong painkiller) for [their] pain. [They] asked for it the other night and the nurse told [them] they hadn't got any. So the day nurse had to sort it out and rectify things, as they did have it in stock." A third relative told us that they had seen documentation in their family member's bedroom which suggested that staff were not regularly applying prescribed creams to their family member's skin.

We observed medicines administration on all three floors of the service. An agency nurse was administering medicines on the middle floor and did not know the people using the service. They checked with a senior care staff member as to the identity of the person by asking them the person's room number. They did not confirm the person's full name with the staff member or the person who used the service. This was not safe practice and increased the risk of incorrect administration of medicines.

We saw a nurse on the ground floor remove a person's medicines from their cupboard and put it on the trolley to take to the person but stopped at another person's room and assisted them before going to administer the medicine. On the second floor we saw a nurse get the medicines ready to administer for one person from their room and then get the medicines ready for another person from another room before going to the dining room to administer both people's medicines. These actions were not safe practice and increased the risk of errors occurring and also increased the risk that other people may take them.

Morning medicines administration was not completed until 11.50am on the middle floor on the first day of the inspection. This meant there was a greater risk of people who received medicines at lunchtime receiving medicines without the necessary time between doses and suffering harm.

There were a large number of gaps in the medicines administration records (MARs) indicating either staff had not administered people's medicines on occasions or they had not signed for the administration. We checked the number of tablets remaining for one person and from this, identified their medicine for

depression had not been given on one occasion. We also checked the medicines for two other people with gaps in their MARs and identified discrepancies in the number of medicines remaining as compared to those that should have been left if they had been given correctly. This meant that either the medicines had not been checked in correctly when they had been received from pharmacy or those people were not receiving their medicines as prescribed. This meant that medicines were not being effectively managed to ensure that people received them safely.

Systems were in place for the ordering and supply of people's medicines but staff said the medicines were received late in the week prior to them being required and there were occasions when medicines were not available when they were needed on the first day of the new cycle. We noted one person had missed five doses of one medicine they needed to take to prevent deterioration in their well-being. We also noted another person's medicine had not been available for four days. This meant that medicines were not being effectively managed to ensure that people received them when they needed them.

Most medicines were kept in locked cupboards in people's bedrooms. There was a temperature strip on the front of each cupboard and the temperature had been recorded daily. Most were within acceptable limits, but we noted one had been outside safe limits for several days. This meant that there was a greater risk that medicines stored in this cupboard would not be effective when given to the person.

Some liquid medicines and creams were not labelled with the date of opening to ensure they were only used for a period of time where they were most effective. Records of the application of creams were not consistently completed to show that people were receiving them.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines not stored in individual bedroom lockers, were stored on the ground floor in a locked room. The refrigerator was locked and room and refrigerator temperatures had been checked daily.

MARs had a photograph of the person to aid identification, their preferences for taking their medicines and any allergies recorded on a front sheet. PRN protocols were mostly in place to provide staff with guidance on when to administer 'as required' medicines.

Staff told us they had completed medicines training within the last three months and had had their competence to administer medicines checked recently.

People told us the home was generally clean but some improvements could be made especially the laundry of clothes. A person said, "The home is very clean. They deep clean my room now and then too." Another person said, "It's okay here. But I wish they would iron the duvet covers. I've had two new cardigans and the laundry has ruined them with too hot a wash. And I've lost two pairs of trousers and a pearly button blouse." However, a relative said, "The home is fine and the cleaners are amazing."

A relative said, "[My family member] has daily injections. I was thinking of raising it with the nurses as I've seen them not always using gloves when doing the injection." While the service was generally clean, safe infection control practices were not always followed. For example, we saw continence pads stored out of their protective packaging, people who used the service did not have individual slings, for use with the hoist, putting them at greater risk of infection and a staff member had left faecal stained clothing in a bath. These practices put people at greater risk of infection.

There were plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. An emergency contingency plan was in place to provide guidance to staff to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

Robust systems were not in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. The service did not use a staffing tool to give guidance on the staffing levels required to keep people safe and meet their needs. They also did not monitor the response time to call bells to monitor whether sufficient staff were on duty at all times to meet people's needs promptly. On the first day of our inspection the service was not meeting its own identified staffing levels to meet people's needs.

People raised concerns about staffing levels. A person said, "They could do with some more [staff] all the time." Another person said, "I think they're short but manage mostly. [Staff] get used on other floors too when they're short." A third person said, "They're so short of staff, you have to wait a long while." Feedback from relatives was mixed. A relative said, "We've had issues with the lack of [staff], but to be fair, the last three months have been much better." However, another relative said, "There's always a need for more [staff]." A third relative said, "I've seen them be one to two [staff] short at times."

Most staff felt there were adequate levels of staff in the morning but in the afternoons when there were less staff, it was more difficult to manage monitoring the communal areas and providing care to people who needed two staff to assist. We were also told that sufficient staff were not always on duty to meet people's needs safely at night on the top floor. A staff member said, "There's often only one [staff member] on at night up here [top floor]. In the morning there's four of us, but only three in the afternoon – that's when we could do with more as it's the same amount of care as in mornings, but in reverse getting people to bed at 6pm." Another staff member told us that care was sometimes more task-orientated in the morning due to staffing levels but, "We do give people a choice about when they get up." We observed that people received care promptly although it was difficult to find staff on the ground floor at times.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

Requires Improvement

Is the service effective?

Our findings

Relatives views were mixed on whether staff were sufficiently skilled and experienced to effectively support their family members. A visitor said, "The current team [on the top floor] are incredible. This floor is really good. There's been a massive turnaround since April for some reason." Another relative said, "Some are okay, but new ones have to pick it up. I think they should all be dementia trained too." A third relative said, "I think they're capable and can read [people]'s behaviour. I've seen them doing training too." However a fourth relative said, "Staff don't understand the sensor mats [used to keep their relative safe]."

In the last staff survey some staff had raised concerns regarding the support they received. Issues raised included the approachability of the manager, lack of probationary review, supervisions and appraisals and irregular staff meetings. We found the same issues at this inspection.

A staff member who had recently started at the service told us they had attended a week of training including all mandatory training topics and was supernumerary for the first few days. They said they had had time to read people's care plans and familiarise themselves with people's needs. They said the registered manager had told them that if they were unclear about anything they could speak to her. However, induction documentation had not been completed in any of the files we looked at to show that staff had completed any part of their induction. This meant it was not clear that staff had received a full induction to their role. There were also no records to show that staff had been subject to a probationary period and that their performance had been reviewed regularly before their probation had ended. This meant that it was not clear that new staff had received adequate monitoring of their performance and support to ensure they were competent to effectively meet people's needs.

One staff member said, "We've had a lot of training here." They said they had completed their mandatory training and had recently done some online training which they had been required to complete in their own time at home. However, we did not receive training figures during the visit so could not confirm that all staff had attended all relevant training. We requested that this information be sent to us following our visit but the service did not send it to us.

Some staff told us they had had supervision approximately every three months whilst others told us they had not had any supervision. A staff member said, "I can't remember when I last had supervision." Staff told us they had not had an appraisal.

The majority of staff had not received recent supervision. Most supervision records that we saw contained the same items for discussion and did not show that staff had been able to discuss issues that were important to them or receive constructive feedback on their performance. It was not clear whether any staff had received an appraisal. This meant that not all staff were receiving sufficient support to carry out their role effectively and make any improvements if needed.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt staff were sufficiently skilled and experienced to effectively support them. A person said, "I think so [well trained]." Another person said, "Most are pretty good at what they do."

Adaptations had not been made to the design of the home to support people living with dementia. Some people told us that other people who used the service came into their bedrooms at times and we saw that not all people's bedrooms were identified with their name on it. A staff member told us that they wished the signage on the toilets and bathrooms was dementia friendly, rather than just a small brass sign. They said that often people are seen looking for the toilet but could not locate it. Bathrooms and toilets were not always clearly identified and there was no directional signage to support people to move independently around the home. A number of lights in corridors and bathrooms were not working or were very dull which made it more difficult for people to move safely around the home.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views were mixed on whether staff checked before assisting them. A person said, "They always ask me first." Another person said, "Sometimes they'll ask me." A relative said, "Some [staff] talk to [my family member] and explain as they're doing something. Others do it in silence." Where people expressed a preference we observed that staff respected them.

We saw that some people had consented to their care and for the use of photographs in their care record. One person had a Lasting Power of Attorney in place for health and welfare and their attorney had given their consent to their care plans and to the use of photographs and annual vaccinations. Bed rails were being used to prevent some people falling out of bed and people had given their consent to their use. This meant that records showed that staff were obtaining people's consent to care where possible.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The requirements of the MCA were not being consistently followed. When a person lacked the capacity to make some decisions for themselves; a mental capacity assessment and best interests documentation had not always been completed. For example, one person did not have any mental capacity assessments in place despite them being unable to make some decisions for themselves.

Another person's bed rails assessment said the person was unable to consent and so they were being used in their best interests. We noted they also had a sensor mat in place to alert staff to their movements to reduce the risk of falls but there was no capacity assessment and best interest decision in relation to this. However, there was a capacity assessment and best interest decision in relation to them living at the home and maintaining their safety. This meant that there was a greater risk that some people's rights were not being fully protected.

DoLS applications had been made for a number of people who used the service and some of the applications had been authorised. We checked the records of a person who had a DoLS authorisation in place and saw they were receiving care in line with the authorisation. Staff told us they had completed training in mental capacity and DoLS. Senior staff were able to describe the basic implications for their practice and more junior staff said they would refer to the senior staff.

We saw the care records for people who had a decision not to attempt cardiopulmonary resuscitation (DNACPR) in place. There were DNACPR forms in place and they had been fully completed.

People's feedback on the food was mixed. A person said, "It's pretty good. You get a choice in the dining room but not in your bedroom. Three days last week we had mince every day in a different guise. We never have anything fancy like cauliflower cheese or salads. I've never had a salad, when I mentioned it, I was told 'You've only got to ask' but how do we know that?" Another person said, "It's not bad. We get a bit of a choice and I request different things like a jacket potato or omelette and chips." A third person said, "It's alright, it's adequate. There's normally two things to choose from." A fourth person said, "You can't grumble. It's not gourmet, we get what we get. You can say if you don't like it though."

People told us they had sufficient to drink. A person said, "I've got my jug of water here [in their bedroom] and get lots of tea a day and some squash." Another person said, "I can get juice if I ask and we get hot drinks given. I've got my own drink supply too." A relative said, "She's always drinking and being reminded [to drink]."

We observed breakfasts being served in the dining room on the first floor. A senior carer was based in the dining room and was attentive to people's needs. People were given a choice of a hot breakfast of bacon, tomatoes and toast or porridge. When someone did not eat their meal for a prolonged period the staff offered them an alternative. When people had eaten their food they were asked whether they wanted more to eat.

We observed lunchtime on all three floors. People were appropriately supported by staff if they required assistance when eating. In the dining room on the top floor, three people living with dementia were seated together and received good encouragement from the staff member on duty to eat more of their meal.

We saw that a person had been identified as at nutritional risk and staff had involved a dietician. The dietician had advised that the person be offered snacks between meals and the person's care plan also stated this. We looked at the person's food charts and snacks were not recorded as being offered to the person. We also saw that the person was generally receiving food around 4.30pm and then not recorded as being offered any food until 9 or 10am the following day. This meant records indicated that the person's nutritional risk was not being effectively managed by staff.

We saw that nutritional risk assessments had been completed for other people and care plans were in place to identify people's dietary needs and preferences. People's weights were being monitored by staff. Food and fluid charts were in place to record people's intake. However, these were not consistently completed to show that people were receiving sufficient amounts to eat and drink.

People told us they saw other professionals when required. A person said, "I was tested here last week and am getting new specs. I see the chiropodist every few months." Another person said, "They get the doctor out quite quickly when I'm poorly." A relative said, "I can't fault them. They've been quick off the mark for [my family member] with the GP. She's had the hearing people in, plus had her feet done."

We saw there had been prompt referrals to other healthcare professionals when these were required. A person with diabetes was having their blood sugar level monitored. There was evidence that medical advice had been sought when the person's blood sugar level was very high.

However, we saw that a person's physical healthcare need had not been promptly recognised by staff. A relative said, "[My family member]'s got sores on [their] heels at the moment and [staff] didn't know [they]'d got them. [My family member] is diabetic too. The sores weren't found until they'd started bleeding 2-3 weeks ago." We saw that a person had developed two pressure ulcers. These were deep ulcers before they were identified by staff, which indicated that the person's skin had not been competently checked regularly. As soon as they were identified, the person was referred to an external healthcare professional for advice and a wound care plan was put into place. However, there was no regular wound assessment in place to record progress of wound healing systematically. This meant that there remained a greater risk that the person's wound was not being effectively monitored to ensure that it was being effectively managed.

Requires Improvement

Is the service caring?

Our findings

People we spoke with were generally complimentary about the kindness of staff. A person said, "They're all kind." Another person said, "Most are caring." A third person said, "They're very kind here." However a fourth person said, "The odd one or two aren't as genuine but we have to put up with it. If they're sharp to you, you're sharp back and I say 'Who'd you think you're talking to!'"

A relative said, "[Staff] are super people." Another relative said, "Most are kind to her. Some are lovely girls." A third relative said, "The [staff] are really lovely and will spend time with [my family member] and give her a hug."

Staff had positive relationships with people living at the home and we saw staff greeting people warmly when they entered the room. People responded with a smile and some of them gave staff a hug. Staff had a good knowledge of people and their needs. A person said, "They know me very well and listen mostly."

We saw staff asking people for their preferences and giving them time to answer when they hesitated. Staff told us they always gave people choices and when they had difficulty in making choices they simplified the choices to make it easier for people. Where people could not communicate their views verbally, their care plan identified how staff should identify their preferences and staff were able to explain this to us.

A person said, "They sometimes involve me and my social worker comes as well." Relatives we spoke with told us that generally they felt informed about their relative's care but no-one could recall specific reviews or planned meetings. A relative said, "They keep us in the loop and we always ask anyway when we're here." Another relative said, "Sometimes I have to ask, sometimes I'm told how she is." However a third relative said, "We've not seen a care plan. I look at the charts here in [my family member's] room but have had nothing at all to do with the office."

Care records contained limited information to show that people or their relatives, where appropriate, had been involved in the care planning process. We noted some people had signed to say they had consented to their care plan, but there was no evidence of their involvement in regular reviews. Advocacy information was not available for people if they required support or advice from an independent person.

People's dignity was not respected at times. A relative said, "[My family member] didn't have a bra on today, didn't have one on yesterday." We saw that staff had not ensured that people's catheter bags were covered when in bed and in communal areas.

People told us that their privacy was respected by staff. A person said, "[Staff] all knock [before entering] and wait." Another person said, "When I'm dressing they keep everything closed." A relative said, "Privacy is good when she's having care." However, another relative said, "Sometimes [staff] don't knock which is annoying. The other week some (male) contractors just walked in to check the alarms – made me jump!"

We saw staff took people to private areas to support them with their personal care and saw staff knocked on

people's doors before entering. The home had a number of areas where people could have privacy if they wanted it. Staff told us they knocked on people's bedroom doors before entering and closed curtains and doors during personal care. However, we saw that staff did not always treat information confidentially as some care documentation was left unattended in communal areas.

People told us that their independence was encouraged by staff. A person said, "They let me wash my face then they do the rest. I choose what I'm going to wear." Another person said, "I decide on when I want to go to bed or get up. I always decide my clothes too."

Visitors told us they visited regularly, at any time, without appointment. We saw staff reminding people when they were expecting relatives to visit. Staff told us people's relatives and friends were able to visit them without any unnecessary restriction.

Requires Improvement

Is the service responsive?

Our findings

People's views were mixed on whether they always received care that was responsive to their needs. A person said, "You don't have the continuity, like one staff member will talc me after a bath and another one will say they're not supposed to." A person said, "I don't really make many choices apart from clothes as I'm tied to their times, especially as there's no hoist." Another person said, "They shower me when they've got time. The bath is broken at the moment and has been for a few weeks so it's just showers at the moment."

A person told us that staff had not effectively supported them the previous night. They said, "They didn't turn my catheter on last night – they put the night bag on but didn't turn the valve so my day bag leaked all over the bed in the night." However, another person said, "I definitely get what I need doing." A relative said, "[My family member] definitely gets the care she needs."

People did not feel that staff spent time with them when not specifically providing care. One person said, "Five minutes and then they're off." A relative said, "We don't see anyone else sitting with her." Another relative said, "Staff don't spend as much time [with our family member] as we'd like."

Some people felt that their preferences on the gender of staff member supporting them were respected, others were not sure. A person said, "I don't want the men – I say no." A relative said, "A staff member said to me the other day 'We should have asked her first if she minded a man, when he went in one day.'" Another relative said, "When she first came, she only wanted females hence the 'Ladies Only' sign. But needing two on the hoist, I don't expect we can choose now if a male is the only staff member available."

Care plans contained limited information about people's interests and activities they enjoyed although a small number contained a personalised document which provided some additional information. Limited records were kept of people's involvement in activities or hobbies that they were interested in.

Some people's care records contained a short one page "service user profile" with information about what was important to them. For one person it said having their bible with them was important, but on the day of the inspection, we saw it was in their bedroom on a shelf away from the bed when they were in the lounge.

People's care records contained a pre-admission assessment and a diet notification sheet to summarise people's dietary preferences. However, these assessments were sometimes very brief and contained little detail. For example a person who was overweight had not had this identified on their assessment and this would have influenced the equipment which was needed to support them safely.

Information in people's care plans did not always provide sufficient guidance for staff to meet people's individual needs. Some care plans contained the necessary detail whilst others lacked important information or did not reflect the person's current care and support needs. For example, one person's care plan stated they should be checked every 30 minutes as they could not use their call bell. We were told they were not formally checked but staff observed them when they were passing the room. A staff member said, "We haven't done half hourly checks for a long time." Another person had not had their care plan updated to

reflect the advice of a professional who had reviewed their care.

Health care plans were in place to enable staff to manage people's health needs effectively. For example a care plan was in place for someone who had had a stroke and a person with epilepsy. Another person had a diabetes care plan and there was evidence of reviews by the diabetes specialist nurse regarding blood sugar levels. However, there was no evidence of an annual diabetes review or eye and foot screening in line with NICE guidance. This meant that there was a greater risk that health concerns regarding this person's long term condition would not be promptly identified.

Records indicated that staff did not always effectively manage situations when people had behaviours that might challenge. Documentation described an incident where a person had become verbally and physically challenging and appropriate requests for support had not been made by staff during or following the incident. A further incident took place on the same day involving the same person which might have been avoided had the earlier incident been better handled.

Behaviour care plans were in place to provide information for staff about people who had behaviours which others might find challenging and the way the person should be supported when they were distressed. However, these varied in the level of detail provided and for one person, they did not provide an accurate picture of the person's behaviour. This meant that staff did not always have guidance in order to effectively support people with behaviours that might challenge others.

Behaviour records were not always completed as indicated in care plans in order to monitor people's behaviour and consider the reasons for it. This meant that there was a greater risk that the reasons for people's behaviour would not be identified and measures not put in place to more effectively support people with behaviours that might challenge others.

People told us that activities needed improvement. A person said, "No, there's not much on. There's sometimes a sing song in the lounge. Nothing happens here in my room so I watch TV or have talking books on. I've not heard of any outings." Another person said, "They do sometimes do things. We can go downstairs if there's a singer on. In the lounge up here, it's the TV. Nothing really happens." A third person said, "We just sit in the lounge." A relative said, "[My family member] was getting stir crazy so we come in regularly. She's deaf so can't hear any music or quizzes."

During the inspection we saw limited activities taking place. People spent a lot of time sitting in the communal lounges without being engaged in activities or by staff. The home had an attractive garden area and the weather was generally good during our inspection. However we did not see many people being supported to use the garden. A person said, "No, there's not really anything. We're bound to get bored – we have to please ourselves. I'd like to be outside and see some fields again." A relative told us they would like to see more people going outside.

An activities coordinator was employed but was on leave during our inspection. Staff told us that they felt there should be at least two activity coordinators working in the home and told us that they had received complaints about the level of activities offered. A member of staff said, "The biggest issue is the activities. We need another person. The carers can't do many activities as they don't have the time." We saw staff sat in the lounge with people during the day but most were completing paperwork rather than engaging with people and initiating activities.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us that staff responded promptly to requests for assistance. A person said, "[Staff] come fairly quickly." Another person said, "[Staff] come within a few minutes usually." A third person said, "[Staff] soon come." However, a person said, "I can have a long wait sometimes and it's a bit annoying if I need the toilet. I needed it the other day and it took two hours as they were short and needed to find a hoist, so I had tummy ache from holding on." We raised this issue with management who agreed to look into this issue.

A relative told us that staff had not effectively dealt with their concerns. They had raised concerns about their family member's care on a number of occasions but their concerns had not been effectively addressed by staff. Staff told us if a person wanted to make a complaint they would listen to the issue and try to resolve it if they could. They said they would explain to the person they could speak to the manager. Staff said they received feedback on complaints at handover and tried to ensure the issue did not recur. One staff member said, "We try to improve and rectify the issue."

The home's complaints information was filed in the safeguarding folder. No formal complaints had been recorded so we could not check whether complaints had been appropriately responded to. Guidance on how to make a complaint was displayed in the main reception area but did not contain contact details for the local Government Ombudsman and complaints guidance was not included in the guide for people who used the service. This meant that there was a greater risk that people would not know how to effectively make a complaint.

Inadequate

Is the service well-led?

Our findings

During our previous inspection on 3 December 2015 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems in place to monitor the quality of the service had not been effective. The provider sent us an action plan and told us they would be compliant with this regulation by 30 April 2016. However, at this inspection we found that improvements were still required in this area and the regulation had not been complied with.

The provider had a system to regularly assess and monitor the quality of service that people received, however it was still not effective as it had not identified and addressed the issues we found at this inspection. We saw that some audits had been completed by staff working in the home in the areas of catering, enhancing mealtimes, infection control, medicines and care records. However actions were not in place in response to all identified issues.

We also saw that audits had not been taking place regularly to ensure that shortcomings were identified and dealt with promptly. For example, care records had only started to be audited from June 2016 and so some care records were only first audited in June 2016 and most had not yet been audited. Medicines audits had also started to be completed from June 2016. Some of these audits had details of actions to be taken to address the issues raised but others did not. An external medicines audit had also been undertaken and identified some of the issues we raised. Some of the actions in the action plan from the external audit had been addressed, but others had not. This meant that effective processes were not in place to ensure that improvements were made when required.

We asked to see evidence that representatives of the provider not directly employed at the home were completing audits. We were told that they were and we requested that this information be sent to us following our visit but the service did not send it to us. This meant that we could not be sure that representatives of the provider not working at the service were checking to ensure that staff working at the home were effectively monitoring and auditing the service.

Improvements to the service had not been made and sustained following inspections by external organisations. The CQC inspection in July 2014 identified breaches in regulations. The subsequent inspection in February 2015 found that these regulations had been complied with, however, the service was rated 'Requires Improvement'. At our previous inspection in December 2015 a number of areas were also identified as requiring improvement but had still not been fully addressed by the time of this inspection. This included the reporting of safeguarding issues, medicines management, consistent application of the MCA, involving people in decisions about their care and the level of activities offered by the service. We also saw that areas identified by commissioners at more recent visits had also not been fully addressed. This meant that effective processes were not in place to ensure that improvements were made and sustained when required. We have been informed Commissioners have currently suspended placements at the service.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not aware of any meetings they could attend to share their views on the running of the service. A person said, "I've not heard of anything like that." Another person said, "No, I don't know about that." We saw that a meeting for people who used the service had taken place. However, the minutes of the last meeting did not note who had attended and it was not clear whether any actions had taken place in relation to an identified issue. A meeting for relatives had also taken place but again it was not clear whether concerns raised at that meeting had been addressed. A relative said, "We've been to relatives meetings it's nice to get things off your chest but if anything was done after, is another matter. The last one we went to was before Christmas. There were no minutes when we asked in March!" This meant that effective systems were not in place to respond to comments made by people and relatives regarding the running of the service.

Management told us they were awaiting the results of the last survey completed by people who used the service. We saw that surveys had been completed by relatives regarding the quality of the service. Some issues had been raised and actions had been identified to address them. A suggestion box was also in the main reception area. A relative said, "I feel they listen but when they're busy, they forget. They just make the right noises."

We asked to see a whistleblowing policy but it could not be found. Management told us that staff often raised issues with external bodies if they had concerns about the home. A member of staff told us that they felt that they had not been encouraged to be open and transparent at a previous CQC inspection. This indicates that an open culture was not in place in the home. This meant that there was a greater risk that management would not be aware of issues that required addressing to ensure that people received a good quality of care.

The provider's values and philosophy of care were in the guide provided for people who used the service. However we noted that one of these stated that, "… the home is a learning environment for the growth and professional development of our staff at all times…" We did not find that this was the case at our inspection which meant that effective systems were not in place to ensure that the provider's values were being followed by staff so that people received a good quality of care.

Staff commented on the repeated changes at the home and they said it was de-motivating. One person said, "It's normally okay but people are getting tired. Staff leave and they are not replaced quickly enough." Some staff told us the teams worked well together whilst in other areas some of the staff didn't work as a team and did not "pull their weight." Another person said, "You get some carers who can't be bothered, but others go the extra mile for the residents." This meant that there was a greater risk that the quality of care was not consistent across the home. However, staff told us the acting manager was aware of the issues and was starting to address them.

We received conflicting views on the management of the home; with some confusion also voiced on which person was the current manager. A person said, "I've not seen her." Another person said, "We don't know who's who now." A relative said, "There's been four of them in two years so we've no idea who it is at the moment." Another relative said, "We wouldn't know who it is now. I'd sooner talk to the senior anyway."

We saw that staff meetings took place, however they were not held regularly. Staff told us there had been several changes to management which had been unsettling. However, staff were positive about the acting manager. For example, "[The acting manager] is very responsive. She is there for us if we need her." Another person said, "[The acting manager] is brilliant. I wish she could be our manager."

Staff survey findings were displayed near the reception. Some staff had raised concerns regarding the

approachability of the manager, lack of probationary review, supervisions and appraisals and irregular staff meetings. We found the same concerns at this inspection suggesting that effective actions had not taken place in response to these issues which could affect the quality of care received by people.

A registered manager was in post but she was not available during the inspection and was no longer working as the manager of the home. An acting manager was in place on a temporary basis and was available during the inspection. However, no application to register a new manager had been received by the Care Quality Commission (CQC). We saw that all conditions of registration with the CQC were being met and most statutory notifications had been sent to the CQC when required. However, notifications were not being sent to the CQC when DoLS had been authorised. The current CQC rating was clearly displayed in the home; however it had not been displayed on the provider's website at the time of our inspection. This meant that the provider was not meeting their regulatory responsibilities in full.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that was responsive to their needs and activities required improvement. Care records contained some information to support staff to meet people's individual needs but could be further improved.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Identified risks to people were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Potential safeguarding issues had not been reported or not reported accurately putting people at greater risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People's needs were not fully met by the adaptation, design and decoration of the service.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Not all staff received appropriate induction, training, supervision and appraisal.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe medicines practices were not always followed.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and improve the quality of the service provided were not effective.

The enforcement action we took:

Warning notice