Countrywide Care Homes (2) Limited

Dussindale Park

Inspection report

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Date of inspection visit:
20 August 2018

Date of publication:
27 September 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 20 August 2018. At the last inspection carried out on 25 and 26 May 2017, we found that there were areas which required improvement. At this inspection, we found that the service had deteriorated and there were more areas which required improvement. We found five breaches of regulations relating to keeping people safe, staffing, person-centred care, mental capacity and governance.

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

Dussindale Park accommodates 58 people in one adapted building across two floors. There were 43 people living in the home when we inspected, many of whom were living with complex health conditions.

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. The registered manager was not available at the time of our inspection, and we were supported to carry out the inspection by other members of staff, such as administration, quality assurance staff, nurses, and the deputy manager.

Risks to people were not always properly assessed and mitigated. There was not always accurate guidance for staff on how to mitigate risks to people associated with their mobility, choking and associated long-term health conditions. People did not always receive medicines as they had been prescribed, and there were gaps in recording around people's topical medicines such as skin creams.

There were not always enough staff deployed throughout the home to ensure that people received support in a timely manner.

People who lived with variable mental capacity did not always have their capacity assessed in line with specific decisions about their care. Records did not support that decisions were always made by staff in people's best interests, or that they were only deprived of their liberty in the least restrictive way available. Staff had not always sough consent from people about their care.

Care plans were not always completed, and there were inaccuracies and inconsistencies. People did not always receive individualised care according to their diagnosed health conditions, needs and preferences. There were not always activities or occupation on offer to people based on their interests, life histories or hobbies.

Accurate, contemporaneous records of people's care were not always kept. The quality assurance systems in place had not always identified areas for improvement.

Staff received training relevant to their role, however they did not receive training in the complex health conditions which people they cared for lived with. Nursing staff had their competencies checked regularly.

Staff were kind to people but at times rushed to deliver care. Family members were consulted about some areas of their relative's care, but there were no records around people themselves being involved in their care.

There were recruitment checks carried out to ensure that staff were suitable to work with people living in the home. Staff had knowledge of safeguarding and reporting concerns.

There was a choice of meals available and people received enough to eat and drink. The cook had good knowledge of how to prepare specialist meals for people.

Staff supported people to access healthcare professionals and appointments.

There was a complaints procedure available and we saw any concerns were investigated and resolved. The home had also received many compliments.

There was good team work in place and staff worked well together. They felt supported by their management team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people were not sufficiently identified and mitigated, and there was not always accurate guidance for staff.

There were not always staff available to people when they were needed.

Medicines were not always administered as they had been prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's mental capacity had not always been properly assessed for individual decisions relating to their care. Best interests' decisions and consent had not always been sought regarding aspects of people's care.

Staff received training related to their role, however there was no specialist training relating to the management of long term, complex health conditions

People had enough to eat and drink and were given a choice.

People were supported with access to healthcare when they needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were left alone for long periods of time and staff were sometimes rushing.

Staff knew people well and what they liked and disliked. They also had good relationships with people's families.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were limited activities on offer, and there was no evidence that these were based on people's hobbies or interests.

Care planning was not always done in a person-centred manner, and care records were not properly reviewed and kept up to date.

There was a complaints process and concerns were investigated thoroughly.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance systems in place had not identified the issues and concerns that were raised during this inspection.

The staff team worked well together and the management team were approachable.

Dussindale Park

Detailed findings

Background to this inspection

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

The inspection team consisted of two inspectors, a medicines inspector, a specialist advisor who was a nurse, an assistant inspector, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. One of the inspectors was shadowing the medicines inspector. The member of the CQC medicines team looked at how the service managed people's medicines and how information in medicines records and care notes supported the handling of their medicines.

Before the inspection, we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we also obtained feedback from the local authority.

We spoke with seven staff members including the deputy manager, the quality assurance area manager, a cook, two care staff and two nurses. We also spoke with seven people living in the home and seven relatives. As there were some people who were not able to give us verbal feedback about the care they received, we also made observations throughout the day of support delivered and interactions around the home. We looked at nine care plans in detail, and the medicines administration records (MARs), as well as a range of quality assurance and health and safety records.

Requires Improvement

Is the service safe?

Our findings

We last inspected this service in May 2017 and it was rated 'Requires Improvement' in this area. At this inspection we found that there were further shortfalls and improvements required in this domain. Therefore, it continued to be rated, 'Requires Improvement' in safe with two breaches of regulations.

Risks to people were not always fully assessed or mitigated. There was not enough guidance for staff on how to mitigate risks to people. For example, where people required prompting with their mobility, there was not always guidance for staff on how to prompt people and what equipment they should be using. One person's care plan stated that they used a 'stick' to mobilise, and that staff could support them with this. It did not say how they should physically support the person. In another part of the care plan it stated that the equipment they required was a 'quad stick' and in another it was described as a 'tripod' this could lead to the wrong piece of equipment being given to the person to use. Another person's falls risk assessments had not been completed. For another person who had highly complex needs, the general risk assessment in their care plan was not filled out at all. Therefore, there was inconsistent and insufficient information available for staff.

There was contradictory advice regarding people's mobility. For one person, within their personal fire evacuation plan (PEEP) written in February 2018, it stated that they walked with one staff member. This had been reviewed monthly up until July 2018 with 'no change' recorded by staff. The person's corresponding moving and handling assessment for fire evacuation stated 'independent, possible staff needed if upstairs, which was written on April 2017, and reviewed monthly from November 2017 to July 2018. However, the care plan stated in the event of evacuation the resident would need an evac mat or a mattress with four people for vertical or horizontal evacuation. This was dated 20 July 2018. Therefore, staff did not have the information they needed to ensure they knew how to support the person in the event of an emergency such as a fire.

There was not always safe use of bed rails. Although there were risk assessments in people's care plans, these were not always accurate and they were not always followed by staff. One person told us they were not able to get up at night because bed rails were in place. However, the risk assessment said they were not to be used until the person had consented or a best interests' decision was reached. Therefore, there was a risk that this had not been assessed properly, including the likelihood of the person attempting to get out of bed themselves but staff had proceeded with installation of the bedrails.

There were no care plans in place for positioning. For example, where people had severe muscle contractures or partial paralysis due to stroke or Parkinson's, there was no guidance for staff on how to position their legs or upper limbs to avoid injury or discomfort. People had care plans for changing their position when they were cared for in bed, however this was not sufficient for people with complex movement disorders. One person had a serious pressure ulcer, and there was no care plan in place for their positioning which took this pressure ulcer into account. We saw from records that this wound had significantly deteriorated since it was first noted in March 2018. The only care plan which had been created for the wound was dated 24 June 2018. There was no evidence of a referral to a tissue viability nurse and no

root cause analysis had been completed. There had been no consultation with an occupational therapist about this person's positioning to ensure risks were mitigated. It was not clear how the wound had developed and we could not be assured that the wound was not avoidable and had been managed properly. We informed the safeguarding authorities of our concerns following the inspection.

People's risk of choking was not always recorded consistently or accurately. We saw in three people's care plans that they had conflicting information about whether they had a soft diet or not. Two of these were because the care plan had not been updated in a timely manner with this information. Another had a diet notification form dated 13 July 2018 which stated they should have a soft pureed diet. The palliative care plan dated the same day stated normal diet and fluids. Therefore, there was a risk that staff could obtain the wrong information and give people the wrong food or drink which could cause them to choke. There was no guidance for staff in people's care plans who were at risk of choking, around what to do in the event of choking. For example, one choking risk assessment had a list of elements and these were scored. However, the form did not have a rating scale to show what the numbers related to and then what the implication of the scores were.

There was not always safe management of people's medicines and they did not always receive them as prescribed. This meant that there was a risk to people's health and welfare.

People who had prescribed barrier creams to support the prevention of pressure areas, did not receive these as prescribed. Body maps that we saw were not in use to show staff where on the body these medicines should be applied, and the medicines charts were only sporadically signed. This included the records for one person who had sustained a serious pressure ulcer. We found inconsistencies in the creams listed in people's care plans, and those they were actually having according to the daily records. Therefore, we could not be assured that people were having their creams administered as the prescriber had intended.

Records were in place for medicine administration with prescribed instructions. However, we found some discrepancies in the records including for one person's higher risk anticoagulant medicine, warfarin. Therefore, records did not confirm the medicine had been given to the person as intended by prescribers. There were some gaps in records such as recently for a person's insulin by injection where the tea-time dose may have been missed and also for external medicines such as creams. We found that some people's medicine charts had not been accurately checked and updated leading to the potential for error. We noted that because of this, one person received an incorrect dose of insulin on the morning of our inspection. There was personal identification and information about known allergies and medicine sensitivities, but the medicine sensitivities recorded for some people were inconsistent and were not always written on the medicine charts so could have been missed. Records for another person showed that they regularly did not have their morning medicines because they were still asleep, however, there had been no further attempts to give them their medicines later.

When people were prescribed medicines on a when-required basis (PRN) there was written information available to show staff how and when to give them to people. However, for medicines of a potentially sedative nature, there was insufficient detail about when staff should consider using them after other non-medicinal interventions had been attempted. For one person, prescribed such a medicine, records showed they received the medicine twice each day and not only on an occasional when-required basis as would be expected. For people prescribed more than one pain-relief medicines on this basis the written information was not clear about the overall strategy for pain-relief and when it was appropriate to give each pain-relief medicine. For people who were unable to tell staff about their symptoms, there was an initial assessment tool used for pain but assessments were not completed at times when the pain-relief medicines were needed, to enable staff to know consistently when to give them.

Where people had PRN laxatives and were not able to tell staff about their symptoms, there was no individualised guidance in place about when to administer these. One relative told us that staff did not always record bowel movements when they should. They said they stopped a nurse giving their family member a laxative when they did not need it, and they were concerned as they would have been given the laxative and this could have upset their stomach. Another person's continence assessment stated they had a 'normal' history of bowel function, but they were being administered two types of laxative.

Although most of the home appeared clean there were certain rooms that required attention. There were some malodours present throughout the home when we arrived, which were alleviated somewhat towards the afternoon. Not all bedrooms were kept clean, for example, one bedroom had a dirty floor and unpleasant smell, which was checked on throughout the day and was not cleaned. We also noticed a strong malodour in another room throughout the day, and one relative told us they kept their family member's room clean themselves. The dining room was not cleaned after breakfast until five minutes before lunch. Where people had recently had infectious conditions, there were no specific care plans around them so that staff had detailed guidance on how to manage the condition or how often to take a swab to check for infection.

The above concerns resulted in a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt there was enough staff. However, all except one person living at the service, who we spoke with felt that they did not always get support from staff in a timely manner, or that staff were rushing. However, another person said when we asked if staff were available when they needed them, "Sometimes they take a long time because there're helping other people with their breakfast and I have to wait." Another said, "Perhaps 20 minutes, maybe longer. I might have an accident if I have to wait too long." This was closely reflected by another person, "Some mornings I become a little stressed because I want to go to the bathroom but can't manage on my own, they're very busy in the morning." A relative of one person told us, "It's very good and I'm not unhappy with [relative's] care but most people stay in bed because there isn't time to get people up, I think they might need more carers." During the inspection one inspector heard a person calling for help, and went to see why they were calling. They had been left with no call bell, their walking frame out of reach and no drink within reach. They were crying and said they had been waiting for someone to hear them, they said they had been waiting about half an hour. They said this happened regularly during the day, not so much at night, and they were stressed because they needed to use the toilet. The inspector rang the call bell for them, and staff came to support the person.

The feedback we received from people and relatives demonstrated to us that there were not always sufficient amounts of staff available to people throughout the building when they needed support. In some cases, this caused stress, anxiety and impacted on people's dignity as they were unable to access the toilet in a timely manner.

We looked at the staffing rotas and found that the expected number of staff that we were told were on duty, and there were agency staff called in the event on unexpected absence. We concluded that there were not always enough competent staff deployed effectively throughout the service to ensure that people's support needs were met in a reasonable manner. From people's feedback, the problems were mainly in the morning. There was a high number of people who required support from two staff.

We requested a dependency tool from the service which was sent to us a week following the inspection. We could not see from people's care plans how their individual dependency levels were calculated, and that these calculations were accurate given some inconsistent information in care plans. The dependency tool

included scoring areas such as mobility and continence needs. However, there was no assessment which supported the provider's decisions about staffing for areas such as activities. We were not assured that the home was staffed sufficiently, and that the staff were deployed effectively.

The above concerns resulted in a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely for the protection of people who used the service and at correct temperatures. Members of staff who handled and gave people their medicines had received training and had their competence assessed. We observed the latter part of the morning medicine round and saw that staff followed safe procedures when giving people their medicines.

Supporting information was available for staff to refer to when handling and giving people their medicines. There were some written notes about how people preferred to have their medicines given to them, but not for all people. There were some additional records in place to ensure safety. For example, for people prescribed skin patches there were additional charts in place to show where on their bodies they were applied and these had been completed by staff.

Staff were recruited with systems in place to contribute to keeping people safe. This included a DBS (Disclosure and Barring Service) check and references.

Staff had knowledge of different types of abuse and knew what to do if they had concerns about safeguarding people, and how to report concerns. We saw that they received online training in this area.

We saw that equipment was available to staff to prevent any spread of infection, such as aprons or gloves.

The environment was purpose built and had even flooring throughout, however there were some unsightly and unsafe practices which caused hazards. For example, there were lots of wires on the floor in both dining rooms, and these were used to charge hoist batteries. They were a visible falls hazard. People had en-suite toilets, and there were communal bathrooms available. However, these appeared to be used for storing lifting equipment and laundry on the day we inspected. There were communal lounges and dining rooms on each floor.

We saw that any accidents and incidents had been analysed on a monthly basis. Where there were trends however, it was not always clear what further mitigating factors had been put in place. For example, we saw from the monthly analysis report that the incidents where people had been found on the floor were between eight o'clock in the evening and midnight, and there was no further comment or investigation around this. Where one person had sustained a serious pressure ulcer, there was no root cause analysis. Whilst there were reporting systems in place which aimed to review incidents and accidents, we could not be assured that lessons were always learned from these.

Requires Improvement

Is the service effective?

Our findings

We last inspected this service in May 2017 and it was rated 'Good' in this area. At this inspection we found that there were shortfalls and improvements were required in this domain. Therefore, it is now rated, 'Requires Improvement' in effective and there is a breach of a regulation.

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.

The registered manager had recorded mental capacity assessments for people in some areas. These included whether they had capacity to consent to a DNAR (Do Not Attempt Resuscitation), having photographs taken for records or to agree to live in the home. However, there were many decisions which had been taken for people where there was no record of discussion, capacity assessments or best interests decisions. We found for some people, their family members had signed consent forms for them without the appropriate legal authority to do so, and the home had accepted this without adherence to the principles of the MCA. For example, where people refused to follow recommendations from health professionals around their diets. Where their capacity was variable or limited, there was no assessment in place for this specific decision followed by a best interests' meeting with the family and healthcare professionals involved. Therefore, we could not be assured that people were being supported to make informed decisions wherever possible, and having decisions made and recorded to reflect their best interests.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Some people in the home were subject to a DoLS, and we were assured that they were only deprived of their liberty in the least restrictive manner possible. However, the registered manager had not carried out mental capacity assessments prior to applying for the DoLS, which is required in order to establish whether or not one is needed.

Some people told us they were not happy that bed rails were put on their bed at night, and we saw that risks of people falling out of bed had not always been assessed properly. The staff had not always considered least restrictive options for some people. For example, for one person who told us they had bed rails up at night, their care plan stated that bed rails were not to be used until a best interests' decision was arrived at and consent gained. Another person told us they had never fallen out of bed and did not understand why there were always bed rails up. Where people had variable capacity due to their condition, for example stroke or dementia, there had been no specific mental capacity assessments around bed rails or pressure mats, and no discussions around whether these were in people's best interests. Where people had capacity to consent, this had not always been gained from the person.

Staff did not always ask for consent before delivering care. We observed one staff member walk into a

person's room, and tell the person they were going to check them. They then proceeded to get a stand aid and put on gloves and aprons. The inspector asked the staff if they were going to do personal care with the person, to which the staff member answered that they were. They did not ask the person for consent, or offer the person support to go into the bathroom or use the toilet. We spoke at length to this person as part of our inspection and ascertained that they were able to give explicit consent.

Consent had not always been sought from people, as family members had signed consent for people, for example for vaccines and photographs. These family members did not always have legal authority to sign on the person's behalf, as they did not have Lasting Power of Attorney for Health and Welfare.

The above concerns resulted in a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's support requirements were assessed prior to moving into the service and their families were consulted about their histories, where appropriate. This information could then be used to create a care plan.

Staff did not always have thorough knowledge of people's health conditions as they had not always received training around these, for example, in complex conditions such as stroke and Parkinson's disease. As care plans were not always detailed, the limited training in specific conditions meant there was limited understanding of some people's needs, such as communication, changes in swallowing, positioning and emotional needs. Where staff had received thorough training, they had understood it well and applied it to people's care. For example, one member of staff described some virtual dementia training they had completed. They said it had helped them give care in a more careful manner through understanding how people living with dementia may perceive things.

We saw in staff files that they had completed e-learning training on dementia (behaviour which some could find challenging), safeguarding, manual handling theory, and MCA and DoLS. For one member of staff all the above training was completed on one day. Further e-learning courses available included dementia awareness, introduction to care, emergency first aid, nutrition and hydration.

One person told us they felt staff were competent in supporting them to move with a hoist, "I don't like it very much but it has to be done and I'm sure they know what they're doing." A staff member told us how they completed supervisions with senior staff, which involved discussing their strengths and weaknesses and gaining feedback on their role. We saw that nursing staff had various competencies checked, for example in medicines administration, wounds and pressure ulcers and stoma care. We saw that where any concerns were identified, these were discussed with the staff in question. However, there were not specific improvement plans in place for the areas discussed.

A staff member explained how they supported new staff through their induction and shadowing. They said that new staff were buddied up with a more experienced member of staff for as long as needed. All the staff we spoke with told us they received regular supervisions, which was an opportunity for them to discuss their roles and identify any further training needs.

There was a choice of meals available. One person said, "I think the food is very good, there's plenty to eat at lunch time and there's always a choice." This was predominantly reflected by people we spoke with, although one person told us, "The menu for tea is a bit limited though." We saw the menus on offer and spoke to the cook. They told us they made different things for people if they fancied something specific or did not like what was on the menu. The staff had developed a new picture menu which would further

support some people to choose their meals. The picture menus were due to replace the written menus to improve this area of communication. One person told us that at times, things that were on the menu did not get served. We saw that this was the case on the day of our inspection, as salmon was on the menu but it was white fish that was served at lunch, because there was no salmon available.

We spoke with the cook and they showed us their list of everyone's individual needs and preferences. They demonstrated that they had good knowledge of how to prepare special meals, such as soft, pureed, diabetic and fortified. We saw that where it had been identified that people lost weight, a dietician was referred to in a timely manner.

People were supported to drink regularly throughout the day. We saw that staff recorded when people had a drink so that they could monitor whether people were drinking enough. There were also realistic targets in place for staff to support people to drink.

People had access to healthcare professionals. One person said, "The doctor visits every Tuesday but if you're not well when the doctor isn't due in, they (carers) will get the nurse to check you first, if they think you need to see a doctor then they call the surgery." Another person confirmed that they were supported to see a dentist or optician when they needed. Whilst healthcare professionals' visits were recorded, their recommendations were not always written up into a care plan for people. However, staff we spoke with assured us they followed recommendations that were handed over from healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

We last inspected this service in May 2017 and it was rated 'Good' in this area. At this inspection we found that there were shortfalls and improvements were required in this domain. Therefore, it is now rated, 'Requires Improvement' in caring.

People told us that staff did not always respond to their call bells in a timely manner and in some instances, this meant people were not always supported to go to the toilet when needed. This meant that people's dignity was not always upheld. Staff were visibly rushed and not always able to spend meaningful time with people. This in turn added to a feeling that staff were under pressure, which meant they were more task-focussed at times because they did not always have time to interact meaningfully with people, taking the time to support them with what they needed.

We received predominantly positive feedback about staff, although one person told us, "I get on with most but one or two can be a bit sharp." Another said, "They are kind but sometimes very busy." One relative told us they felt the care staff did not always care about the people, and said they often saw them standing around talking. Another person said, "They're all lovely and so helpful. If I need something they always seem happy to help me." A relative told us about a period of time they were unwell and unable to visit, they said, "They [staff] were worried about me and asked me to let them know or they'd call and check I was alright." This demonstrated a caring approach towards people's families. One person explained how staff talked them through things, "When [staff] come to get me up they talk to me about what they're going to do and as they're lifting me, they normally talk to me as its happening." We saw one staff member patiently encouraging someone whilst supporting them to eat their meal in an empathic way.

For the most part, staff respected people's privacy. One person told us, "[Staff] normally ask if they can come into my room, I think they treat this room as my space." However, we saw one staff member go into someone's room without knocking, and proceed to tell them what they were going to do. The person was alert and able to consent to staff going into their room but was not given the opportunity.

People were able to have their rooms personalised according to their own taste. One person said, "I really like my room, it's comfortable and I've got it the way I want it. We were allowed to decorate it the way I wanted it to be."

Some family members told us they were involved in their relative's care. One relative said, "We talk all the time, the carers know what [relative] needs and they talk to me when I visit, I think it works well." Another said they had been kept informed and consulted about their relative's care. However, we could not always see in people's records that they had been consulted about their care in order to support informed decision-making. For example, where people's family members had signed to say they refused recommendations from healthcare professionals or staff, there were no records of discussions with the people themselves.

A relative told us how staff adapted their communication with their family member. They said, "Well it is difficult, of course it is. [Relative] can only say yes and no and sometimes muddles them up but I think they

know [relative] well enough to know what they need." A staff member told us they sometimes used pictures with one person to support them to make choices.

Requires Improvement

Is the service responsive?

Our findings

We last inspected this service in May 2017 and it was rated 'Good' in this area. At this inspection we found that there were shortfalls and improvements were required in this domain. Therefore, it is now rated, 'Requires Improvement' in responsive and there is a breach of a regulation.

People did not always receive care that was individualised and met their support needs and preferences. Where people had complex health conditions, care plans were not always in place to fully meet their needs. We found that care records were not always person-centred, and all the care plans we looked at had inconsistencies and inaccuracies in them. For example, four people's care plans we looked at had a wrong name written in the text. It was clear that care plans were copied and pasted, and staff had not noticed that they contained the wrong names. This included people's end of life care plans. Despite staff signing each month to say they had reviewed the care plan, this had not identified the errors. Not all care plans had been reviewed regularly, and we were not assured that the content was accurate.

Care records did not always contain guidance for staff on managing individuals' symptoms associated with their conditions. Care records were signed as being reviewed regularly, but were not updated as needed or corrected when there were inconsistencies or errors. There were not always care plans in place which guided staff on people's needs. For example, where people had emotional and mental health needs such as depression, there was not always a care plan in place for this. There was not an understanding of people's diagnosed conditions and staff did not receive training to develop this knowledge.

People's end of life care plans were generic, and there were no details of people's preferences if they were nearing the end of their lives. For example, details of how they wanted to be supported and who they wished to be involved in their care. Some end of life care plans had the wrong name in them. A palliative care plan we looked at dated 13 July 2018 stated two pain relieving medicines to be administered regularly, however on checking the MAR, there was no evidence of one of these being prescribed on a regular basis.

Activities and meaningful occupation available for people was very limited. One person told us they spent hours alone in their room and felt lonely, saying, "It's so miserable, I don't see hardly anyone during the day." The activities on the weekly timetable over the weekend each day was 'tea with family and friends'. One person told us, "The sheet says 'Tea with Family and Friends' but that depends whether someone visits or not." Staff and people confirmed that this was not an activity, but that some people happened to have visitors more over the weekend. On Mondays the activity scheduled was 'hairdresser'. This is part of people's general care and not an activity. We saw that the activities timetable included 'shopping', which people and staff told us was where staff asked people if they would like anything, and went shopping for them. This does not constitute a meaningful activity. There was information that had been collected from people and their families about their lives and interests, but this had not been used to create a plan to provide meaningful activity for them. A staff member confirmed to us, "There aren't enough activities. Weekends, [people] don't do anything." They said, "If I've got time on my break, I'll go and chat with [people]." Another member of staff we spoke with also felt activities needed improving. Staff told us that the activities coordinator had been off sick for the last few weeks, and they had not been replaced by staff dedicated to

activities so that people still received this input.

The above concerns resulted in a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us about a trip out they had attended, "There was a trip to the Norfolk County Show when that was on. I think they took anyone who wanted to go, there was three minibuses and everyone who went enjoyed it." They told us, "People had hats and sun cream and plenty to drink, and we had wonderful fish and chips, It was very popular, a good day out." There was regular visiting entertainment such as musical acts once a week. There was also a church service held within the home weekly, as well as some activities such as bingo and a quiz.

People were able to spend their time as they wanted when they were able to do activities themselves. One person said, "If I want to stay up late watching a film then I can, nobody makes me go to bed." Staff said they supported people with baths and showers when people wanted. However, we were not assured that staff always proactively asked people's preferences and had the time to deliver these. One person said, "[Staff] take me for a shower on Wednesdays and help me with that which I don't mind but, I used to have a bath and if I'm honest, that's what I would choose. I think there may be a problem with the bath at the moment and that's why I have a shower." We saw that there were baths available for use during our inspection.

There was a complaints procedure made available for people should they need to raise any concerns. We saw from records that the home had received many compliments from family about their care for loved ones. Any concerns that had been raised had been investigated and resolved appropriately.

Requires Improvement

Is the service well-led?

Our findings

We last inspected this service in May 2017 and it was rated 'Good' in this area. At this inspection we found that there were shortfalls and improvements were required in this domain. Therefore, it is now rated, 'Requires Improvement' in well-led and there is a breach of a regulation.

The quality assurance systems such as the care file audits and the medicines audits, were not always effective. There was a designated quality manager within the organisation who made regular visits to the home, as well as the registered manager and the deputy manager completing quality checks and audits. However, we found breaches, concerns and issues within the home that had not previously been identified.

The checks carried out throughout the home had not identified that some areas were not always cleaned in a timely manner, and there was insufficient storage space, leading to dining areas and bathrooms being used.

Staff did not always keep up to date contemporaneous records. We found care plans with inconsistencies and out of date information, and body maps and records for topical creams were not used properly.

Regular audits of medicines and their records were conducted by the registered manager. In recent months two medicine-related incidents had been reported to ensure they were investigated to help prevent them re-occurring and to promote staff learning, however, these were fewer in number than those that we identified during the inspection alone. These had not yet been identified.

It had not been identified that the service was not compliant with the MCA as a lot of decisions had not been properly considered. Staff had not identified that further care plans were needed in respect of some people's conditions.

People and their families consistently fed back to us that there were not enough staff to meet people's needs in a timely way. Whilst there had been a new system of call bells installed, which enabled monitoring of response times, this had only been completed for July therefore was in its infancy. We could not source assurances through feedback and evidence gathered during the inspection that people always had access to support from staff when they required it and this had not been identified by the organisation.
The above concerns resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The quality manager and the deputy manager immediately began to develop actions from the findings on our inspection and assured us that they would make steps to improve on the areas of concern we found.

There were clear lines of accountability and the management team worked together with the provider's regional team, such as the quality assurance manager who undertook monthly checks at the home. We saw that these were recorded and culminated in a monthly report, with some actions identified. The home worked closely with the staff and management team from other local homes within the wider organisation.

The quality manager told us the home was introducing the role of 'care practitioners' who would undertake further specific training in certain specialist areas and cascade this to the rest of the staff team, and be a 'go to' person for a particular area of knowledge, but this role was not in place at the time of the inspection.

The staff team worked well together and felt supported by the management team. People, relatives and staff told us the registered manager was approachable and they were able to go and talk to them.

The people and relatives we spoke with were complimentary about the registered manager. "[Registered Manager] spends a lot of time in the office but she will roll up her sleeves and muck in." Another said, "We can easily go and talk to them." One relative said they knew where to find the manager but they did not see them around the home regularly. A staff member said, "[Registered manager's] door is always open." Another person confirmed to us that they were always informed of any changes in the home or if there was any planned work in the home which might affect them.

There were meetings which had been held for people living in the home and their relatives, however the last one had been cancelled. There were surveys which people and families had completed to give feedback about the home. We looked at the feedback from 2017, and most of the feedback people gave was positive, some more negative around activities provision. We did not see evidence that changes had been made regarding the findings.

The registered manager had reported notifiable events to CQC and safeguarding authorities when required.

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
Treatment of disease, disorder or injury	Care plans were not always person-centred and there was limited occupation for people. Not all steps had been taken to ensure people received good care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Mental capacity assessments and best interests decisions were not always made in line with legislation. Consent was not always sought from people. 11 (1) (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Nursing staff had not always recorded and reassessed pressure areas consistently to ensure ongoing risk assessment and appropriate treatment 12 (1) (2) (a) (b) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The systems in place for monitoring the service

were not always effective because areas for improvement were not always identified.

17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff available to spend time with people, and people did not always receive support in a timely manner.