Mr Roger Daniel

Red Rose Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Red Rose Nursing Home is a 'care 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.

The care home accommodates up to 68 people across three units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia and is called the memory unit. Another provides nursing care and is called the Willows and another provides residential care and is called Castle. At the time of our inspection there were 53 people living at the home.

There was not 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 provider had put in place an acting manager who was intending to apply to register as registered manager.

This inspection took place on 25 January 2018 and was unannounced. At our last inspection in November 2017 the overall rating for Red Rose was 'Good'. At this inspection we found the overall rating to be 'Requires Improvement'. This is the first time the service has been rated Requires Improvement. We also found breaches of regulation. The provider failed to provide sufficient and appropriately skilled staff to provide safe care to people. People had their liberty restricted but arrangements were not in place to ensure this was in their best interests and in the least restrictive way possible.

On the day of our inspection staff interacted well with people in the memory unit. However in the other two units we found interaction was not consistent. Three of the relatives we spoke with raised concerns about the care their family member received. Staff knew how to keep people safe. The provider had systems and processes in place to keep people safe.

The provider did not have systems in place to ensure the safe management of medicines and consistent recording of medicine administration. Medicines were stored safely and according to national guidance.

We saw that staff obtained people's consent before providing care to them. Where people could not consent, assessments to ensure decisions were made in people's best interest had not been consistently completed.

We found that people's health care needs were assessed and care planned and delivered to meet those needs. People had access to healthcare professionals such as the district nurse and GP and also specialist professionals. Arrangements were in place to facilitate working relationships with other professionals and care providers. People had their nutritional needs assessed and were supported with their meals to keep

them healthy. Where people had special dietary requirements we saw that these were provided for. People and relatives raised concern about the standard of meals.

There was insufficient staff available to meet people's needs. Staff did not consistently respond in a timely and appropriate manner to people. Staff were kind to people when they were providing support. People were not consistently treated with dignity and respect.

An induction process was in place and training was available on a variety of subjects to ensure that they had the skills to meet people's needs. However not all staff had had accessed the training. The provider had a training plan in place. A process for supervision was in place. People were provided access to limited social activities. Relatives felt welcomed and people were supported to maintain relationships that were important to them.

Arrangements were not in place to protect people against the risk of infection. The environment was not consistently clean in Castle and audits did not review staffs practice. In the Willows adaptations had not been made in order to meet people's specific needs.

People and their relatives did not know who the new manager was. Staff did not feel listened to. Relatives were aware of the process for raising concerns but were not confident that they would be listened to. Audits were carried out but action plans were not consistently put in place to address any issues which were identified.

Accidents and incidents were recorded and investigated. The provider had informed us of notifications. Notifications are events which have happened in the service that the provider is required to tell us about. The previous rating was displayed in the home but was not displayed according to CQC guidance on the website.

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.

There was insufficient appropriately skilled staff available to provide safe care.

Systems were not always in place for the safe management of medicines.

Arrangements were not in place to ensure the environment was clean and hygienic.

Risk assessments were completed.

Staff were aware of how to keep people safe and to report incidences of concern.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not act in accordance with the Mental Capacity Act 2005. Documentation was not always clear and best interest assessments had not been consistently completed.

Arrangements were not in place to protect people from having their liberty restricted unlawfully.

Staff had not received sufficient training to support them to meet the needs of people who used the service.

People had their nutritional needs met. However meals were not of a good quality and people's choices were limited.

People had access to a range of healthcare services and professionals.

The environments in two of the units were not appropriate to people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring

People did not have their dignity considered consistently.

Care was provided in an appropriate manner.

Staff responded to people in a kind and sensitive manner.

People were able to make choices about how care was delivered.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records were personalised. However these were not consistently completed.

People had access to a limited range of activities.

The complaints procedure was on display and people knew how to make a complaint. People and their relatives did not consider complaints were responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance processes were not effective in identifying shortfalls in the care people received and improving the quality of care. Action plans were not in place.

Staff did not feel they were listened to. Where issues had been raised by staff and relatives previously these had not been resolved.

The provider had failed to consistently notify the Care Quality Commission of events in line with statutory requirements.

The previous rating was not displayed correctly on the website.

Red Rose Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 January 2018 and was unannounced. It included observations, review of records and policy and discussion with staff, people who used the service and relatives. The inspection was carried out as a result of a number of concerns being raised. As part of the inspection we considered the associated risks linked to the concerns that had been raised.

The inspection was completed by two inspectors, a Specialist Advisor (SPA) 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. An SPA is a professional with specialist skills, in this case they had experience of working with people living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan our inspection.

We looked at notifications which we held about the organisation. Notifications are events which have happened in the service that the provider is required to tell us about. We also considered information that had been sent to us by other agencies when making our judgements. The local authority and the Clinical Commissioning Group (CCG) had developed an action plan with the provider in order to address some of the concerns raised and we reviewed this before our inspection.

During our inspection we spoke with the manager, the regional manager, a bank nurse, an agency nurse and members of five care staff. We also spoke with five people who used the service and eight relatives. We looked at people's care plans and records of staff training, audits and medicines.

Requires Improvement

Is the service safe?

Our findings

We found there were insufficient appropriately skilled staff available across the home. Staff and relatives told us they thought staffing in the castle and the Willows were in sufficient. They also expressed concerns about the use of agency staff across the home and that staff were not always appropriately knowledgeable in order to provide safe care. A member of staff told us, "There are no problems with safety. We just need more staff. A couple of residents need a lot of time and ideally we need six staff on here." Another told us, "We reassure residents and explain what we are doing. We are there for the residents. We do safety checks to stop people falling and have bedside mattresses, alarm bells and chair alarms if people need them"

Although arrangements were in place to ensure when staff were unavailable gaps were filled. We observed that not all the staff were familiar with the service and people who lived there. For example, a relative told us that despite telling staff and leaving instructions their family member was still not cared for appropriately during the night. They told us they were frequently not changed and they found they had been left incontinent. We spoke with a staff member who was familiar with the person. They had recently worked a night and they explained how to care for the person in order to ensure they were dry and comfortable.

Another relative told us, "New staff are coming in and they don't know how to work with [family member]. Agency staff should know but they don't know." They told us they were particularly concerned because their family member required specific care for a condition and they did not think they were receiving it. They told us they had to keep reminding staff to carry out the care.

We looked at staffing rotas and saw in Castle on six occasions in a month the senior member of staff was an agency staff. In addition on three occasions the other members of staff were either agency or staff who were newly appointed, having not been in post more than two months. Neither of the new staff had completed their induction according to records and had not previously had experience of working in a care environment. On the day of our inspection one member of staff had been in post for two months, another for three days and another was an agency. On the day of our inspection the agency nurse on duty on the Willows was on her second shift at Red Rose. The manager stated that they tried to put one of their permanent staff members on duty on the unit each day, however admitted this was difficult as there was only one permanent member of staff on Willows. This member of staff had been employed at the home for several years and was experienced. However the same staff member also had responsibility for new staff and was conducting an induction on the day of our inspection and therefore struggled to divide their time between supporting a new member of staff and advising staff about people's care.

We were unable to ascertain how management could identify whether staffing levels were safe and how this could be evaluated and audited on a regular basis, ensuring peoples' changing needs were being met. A dependency tool was not in use. This was particularly concerning in the Willows as it was evident that there were people with high care and health needs on this unit including one person nearing End of Life. Staffing on Willows unit was provided by a high number of agency staff, including nursing staff. There is currently only one permanent nurse for this unit and they are leaving in February 2018, two nurses had also left the unit the previous weekend, leaving the unit depending on agency and bank nurses. In order to address this

arrangements had been made for a nurse from another home in the group to support the unit for two months. A new clinical lead had also been appointed and was due to commence in February 2018.A bank nurse who was familiar with the home and the residents across all units had been identified to support the clinical lead on commencement of their post.

The nurse in charge expressed some concern regarding 'some of the agency carers.'' They told us. "They have issues with communication and they are complacent about their work. All the carers I had on Tuesday had language difficulties and they had difficulty understanding what I was asking them to do. They don't fill in residents' room charts I'm constantly having to tell them about it. This home is not one of the best, it needs a lot of work here.''

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a total of 15 vacancies across the home on the day of our inspection, however nine of these had been recruited to and the manager was in the process of recruiting to the other posts. The registered provider had a recruitment process in place which included carrying out checks and obtaining references before staff commenced employment. This included Disclosure and Barring Service (DBS) checks to ensure that prospective staff would be suitable to work with the people who lived in the home.

During our inspection we observed people were responded to differently in each of the units. We observed on the Willows people were alone in their rooms or lounge area with very little staff contact. In the memory unit we observed people were responded to promptly. Staff told us they thought there were sufficient appropriately skilled staff available to meet people's needs in the unit. On the day of our inspection the lead nurse for this unit was unavailable however a bank nurse was in place and we observed they were familiar with the needs of people on the unit. However a relative raised concerns about night staff and the use of agency for this period. The provider was looking to recruit a twilight shift onto their memory unit to better manage the ''sun downing effect' 'experienced by many people living with dementia. This has been proven to work well in other homes.

On the Willows we observed a person shouting for help very audibly. A member of catering staff eventually came and left tea which the person was unable to drink without help. Another person appeared to be distressed and was shouting throughout the day. Staff told us they were not sure why they were distressed. The agency nurse told us, "We don't know where the pain's coming from. She's prescribed Morphine PRN and this does help but it makes her sleepy.'' We observed they had been given this regularly. We spoke with the manager who told us the person had a previous injury which could cause some discomfort however the staff working on the unit did not seem to be aware of this. The PRN medicine was administered in the late afternoon. PRN medicine is prescribed to enable staff to provide medicines as and when people require it. Where people are receiving PRN medicine on a regular basis national guidance (NICE) recommends that the medicines are reviewed. There was no evidence of a review having taken place or being planned or a referral to a pain management team. In this case this persons' pain was not managed effectively.

We looked at medicine administration records (MAR) for ten people who lived at the home. Protocols for 'as required' (PRN) medicines were not consistently in place and easily available to staff when administering medicines. These are important because they indicate when these medicines are required and whether or not people could request and consent to having their medicines. When we spoke with an agency nurse about PRN protocols they were unaware these were in place. Where PRN protocols were in place they did not always include sufficient detail to assist staff to understand when people required them. For example, if a person was in pain and was unable to communicate verbally. There was a risk that staff would not know

when to administer PRN medicines. We later saw an example of this which is detailed in this report. People were asked if they wanted their PRN medicines during the medicine round. We looked at the provider's medication procedure which stated that 'medications which are to be given as required must have a PRN protocol.' It also stated that 'PRN medications should be reviewed regularly'. Staff were not following the provider's policy.

People were not consistently protected from infections. In Castle we observed staff were not aware of how to keep people safe from cross infection and did not use protective clothing appropriately. We looked in the bathroom areas and found three dirty toilets with brown stains and a toilet riser with yellow fluid stains. We observed a member of staff supporting a person in the toilet area and not wearing gloves or an apron to prevent cross infection. A system to show when items of equipment had been cleaned was not in place and we found a dirty hoist in use.

We observed staff did not wear aprons or gloves at meal time. A member of staff was seen serving bread for the soup with their bare hands. No side plates were available and the bread was put directly onto the tablecloth. We observed the tablecloths were not consistently clean and had food stains on them. We asked staff if aprons were available and they showed us these were kept in a cupboard in the dining area. Following our intervention staff put aprons on. Another staff member was assisting a person with their sandwiches, breaking them up and placing them into their mouth but did not wear gloves and simultaneously assisted another person with their sandwich in a similar manner. Staff did not understand their roles and responsibilities in relation to infection control and hygiene. Policies and procedures were in place and but were not followed in line with current relevant national guidance.

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

The environment was clean and hygienic in the memory unit and the Willows. Audits had been carried out with regard to cleanliness but not regarding staff practice, for example, handwashing.

We observed a medicine round in three units and saw medicines were given to people in a safe manner and according to their preferences. MARs were completed according to the provider's policy and we saw allergies were recorded consistently. Medicines were stored in locked cupboards according to national guidance.

Individual risk assessments were completed on areas such as nutrition, moving and handling and skin care. Where people had specific issues we saw risk assessments had also been completed. For example, a person required support via a PEG feed and a risk assessment was in place. Accidents and incidents were recorded and investigated to help prevent them happening again. Individual plans were in place to support people in the event of an emergency such as fire or flood.

Staff were aware of what steps they would take if they suspected that people were at risk of harm. They were able to tell us how they would report concerns, for example, to the senior management. Staff told us that they had received training to support them in keeping people safe. The registered provider had safeguarding policies and procedures in place to guide practice and we had evidence from our records that issues had been appropriately reported.

Requires Improvement

Is the service effective?

Our findings

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. We observed people were asked for their consent before care was provided.

We checked whether the provider was working within the principles of the MCA. Where best interests decisions had been completed it was clear from the paperwork what decision they were specific to. However best interest decisions were not consistently in place. One person who was unable to consent had a Do Not attempt Cardiac Resuscitation (DNACPR) order in place however a best interests decision had not been completed. The DNACPR had been agreed by their next of kin who did not have the necessary authority to make decision on their behalf for health issues. Another person had equipment in place to keep them safe at night and a best interests decision was not in place. There was a risk that decisions were not being made in people's best interests. When we spoke with staff they were not consistently able to tell us about the best interest decisions for people.

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 hospital are called the Deprivation of Liberty Safeguards (DoLS). If the location is a care home the Care Quality Commission (CQC) is required by law to monitor the operation of the DoLS, and to report on what we find. At the time of our inspection there were ten people subject to DoLS, Where people had conditions in place we saw these were being met by the home. DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. We checked to see if the provider was following the guidance. We found that the DoLS had been completed according to the guidance. However we also found that applications for DoLS had not been made for some people who had a number of restrictions applied to their daily life in order to keep them safe. There was a risk people were being deprived of their liberty unlawfully. We spoke with the manager and regional manager about this and they told us they were aware of this and were in the process of making applications for a number of people. The policy for DoLS stated that assessments should be completed on admission.

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

People told us they thought staff had the skills to care for them. Staff told us they would like more access to specialist training such as dementia care. When we spoke with the manager they told us they had a dementia course arranged. We saw from the training records that some staff had received training on core areas such as fire safety and moving and handling.

A staff member told us, "I need to update a few things on my training record. I tend to be on shifts when training is delivered. I have been trained on dementia, mental capacity, first aid, safeguarding and health

and safety. The manager checks and tells me what training to do. I have put in to do an NVQ 3. I get supervised six monthly." (An NVQ is a nationally recognised qualification).

The provider had recently employed a member of staff to provide training to all of their locations. A training record and plan was in place however we observed there were gaps in most staff's basic training. Staff told us they had received supervision. This is important to ensure staff have the appropriate skills to care. A support system was not in place for new staff, for example the provision of a more experienced staff member to provider support. We spoke with the manager and the regional manager who told us they were in the process of setting this up.

New staff received an induction. The induction was in line with the Care Certificate which is a national standard. The regional manager told us they were also going to provide an induction for agency staff to ensure they had the appropriate skills and experience. However we observed that not all the agency staff being used on the day of our inspection were familiar with the needs of the people they were caring for. Two of the new members of staff working on shift had not completed their induction. There was a risk staff did not have the skills to provide effectively to people.

Assessments had been completed prior to people moving to the home to ensure the provider could meet people's needs. Care records were personalised and included information about what practical support people required. Where people required specific equipment to meet their needs this had been provided. For example, specialist beds and pressure relieving equipment. We saw care plans had been reviewed and updated. Care records detailed what care people required and how it should be delivered.

People told us they thought the food could be better. One person said, "The food is not so good. All frozen greens are thawed out. No fresh vegetables are used. The potato mash is slushy and horrible. They are trying to make it better." The manager told us they had recently changed from using frozen vegetable to fresh.

We observed people's lunchtime experience. A light lunch was served at lunchtime and people had their main meal in the evening. We saw people were not always offered a choice of meal. For example, people who required soft meals did not have a choice. We observed the soft diet did not look appetising. It was white in colour and was all mixed together. Staff told us that the elements of the soft diets were always liquidised as one meal. When we asked people what they were having people did not know. In addition when people asked staff, for example what flavour the soup was they were unable to tell people. Staff told us if people did not like what was available on the day they could have other options. A menu was displayed on the wall in writing but it was not clear from this what alternatives were available to people.

Staff supported people with their meals at their own pace. For example, we observed a member of staff gently waking a person, checking they wanted to eat and helping with slow and small spoonfuls that they could comfortably manage.

Assessments had been completed with regard to nutritional needs and where additional support was required appropriate care had been put in place. For example, advice to prevent people from choking. Nutritional passports were included in care records. These detailed people's allergies, likes and dislikes and any specific nutritional needs. For example, a person needed to avoid cranberries because of the medicines they were taking and this was detailed in the passport. Records of food and fluid intake was maintained appropriately. This is important to support staff to monitor whether or not people receive sufficient nutrition.

We found that people who used the service had access to local and specialist healthcare services and

received on-going healthcare support from staff. Care plans were also in place to support staff to deliver specific health care. For example, one person had been admitted to hospital the previous evening and staff had accompanied them in order to provide support with their needs.

People told us they had access to the GP and were supported by staff to access this. During our inspection we observed a person's relative had expressed concerns about their family member's wellbeing. The nurse in charge of the unit contacted the GP and they visited the person in order to assess their physical health.

Throughout the home bedrooms were personalised. Bedroom doors in the memory unit were painted in different colours and had memory boxes next to them to help people to identify their room. Directional signage in words and pictures was also available for communal areas such as bathrooms and dining areas. Handrails were painted a specific colour to assist people to identify them. However we observed that some of the handrails had worn and had sharp edges on corners which could cause injury to people. In the Willows we observed the environment was clean and odour free but the decor was bleak and the signage lacked any dementia friendly approaches. As well as bedroom areas people had access to a range of communal and outside areas. We observed a plan of refurbishment was in place.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us that staff treated them well and respected their privacy. However on Castle we observed there were 17 people who used the service, one male and 16 female. On the day of our inspection the staff on duty were one female member of staff and four male members of staff. This meant if people had preference for a female member of staff to assist them with their personal care this would be difficult to provide in a timely manner. A person raised concerns about the number of male staff, they said, "It is difficult if we need a shower." We also observed a male member of staff in a toilet with female resident. The staff member had not put the engaged sign on the door and there was a risk anyone could enter the area.

A relative told us, "Usually staff knock before coming in if the door is closed. Most of the time they respect dignity." We observed that staff knocked on bedroom doors before entering. An award scheme for people and staff was in place to recognise when people had been treated with dignity or shown respect to each other.

Relatives and people who lived at the home said they thought staff were kind, helpful and caring. One person said, "Some staff are more so then others. Some staff have natural sympathy and others don't." A relative told us, "Yes the staff are kind and caring."

Another told us, "They are very kind and I do feel they care genuinely about my [family member]. She is a very loving person and the carers know this and are affectionate towards her in return. [Family member] can still communicate so this is very important."

We observed staff were kind when providing care to people. For example, we observed a member of staff talking to a person about their photograph which was on the wall. They explained that it was the person and also then showed them the other people in the picture, talking about what they were doing. The caring process appeared task orientated on Willows however staff appeared caring and considerate on intervention and were careful to safeguard the dignity of the people they were caring for.

A relative told us, "[Family member] is happy here, we're happy." The person gave us the 'thumbs up' sign when we asked them if they were happy.
Staff explained to people what they were going to do before providing care and asked people if that was alright. When supporting people with their care we saw staff checked that people were happy with their assistance.

Staff ensured people received care how they wanted it to be provided. For example, a care record explained a person sometimes disliked having their hair brushed and it stated, "If [person] is happy and well their hair is not important and can be done later."

People were supported to express their wishes according to their care and their preferences. One person did not have any slippers or shoes on their feet. We asked the nurse in charge about it and they explained

the person disliked their feet being touched or having anything other than socks on. Another person was still in their night clothes in the afternoon. When we spoke with them they told us they felt more comfortable in their nightwear.

Staff supported people to mobilise at their own pace and provided encouragement and support. We saw when staff assisted people to mobilise by using specialist equipment they explained what they needed people to do and explained what was happening. We observed a member of staff supporting a person to sit at the dining table. We observed the member of staff explained what they needed to do and guided them gently.

Staff we spoke with were aware of the importance of confidentiality regarding people's information. A person was waiting to see a GP and we observed when the GP arrived staff asked them if they would like to go to their room in order to have more privacy. We observed three of the records we looked at were poorly maintained and pages were loose. There was a risk records could be lost.

Where people required support from lay advocacy services this was identified in their care record. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes. Information was available to people as to where this service could be provided from.

Requires Improvement

Is the service responsive?

Our findings

People had access to limited activities. A member of staff was responsible for providing activities across the three units. However they were only employed for 16 hours a week and people and relatives told us there were insufficient things for people to do. People we spoke with said that what activities were available were good but there were insufficient to provide support to all three units. Staff also told us they thought there was a need for increased support for activities. On the day of our inspection we saw that celebrations were taking place for Burns Night and this occurred in two of the three units although people were able to attend if it was not in the unit in which they lived.

One person told us, "An activities co-ordinator comes up to Willow. In rooms she does hand massage, nail painting and group activities in the lounge." Another said, "Most of the time people watch T.V. There are activities downstairs but not up here in people's rooms." One person said, "I've nothing to do. I'm sat here all day long. Nobody comes to do anything with me." A relative said, "There are insufficient activities. Not sufficient stimulation." Another said of the Willows, "Some people don't see anyone for a talk up here."

Care records included details so that staff could understand what things were important to people such as information about people's past life experiences and their preferences. Information such as this is important because it helps staff to understand what is important to people and why. Records showed that nurses and care staff had consulted with people about the care they wanted to receive and had recorded the results in an individual care plan. For example, a person became anxious when having a shower and the care record explained, how to provide support in order to avoid them becoming anxious. There was evidence care plans were being reviewed to make sure that they accurately reflected people's changing needs and wishes, however this was not consistent. We also found evidence of records not being fully completed for example, a life history in a care record had not been completed. One person's care plan was not clear about what care a person required and relatives told us discussions had taken place but we saw no evidence of these or subsequent changes to care.

One person was awaiting assessment by the psychiatric services. However we could not find a record detailing the incidences to track these problems, or a risk assessment, however there were records in the daily notes on many occasions. In addition the person was subject to a risk of severe dehydration and urinary tract infections. We observed the nutritional risk assessment was not detailed and did not reflect how this could be avoided. Charts recording half hourly checks had also not been completed. The person was at risk of not receiving the appropriate care due to the incomplete records.

People and the relatives we spoke with told us they were not aware of their care plans. A relative told us, "The home doesn't discuss the care plan with me very much. I have discussed with the home and solicitor if anything should happen in the future. It's documented in the plan and I have a copy at home." When we spoke with the manager and regional manager they told us they were intending to put in place arrangements for reviewing people's care with their relatives.

Relatives told us that they felt welcome at the home and that they were encouraged to visit so that

relationships were maintained. A relative told us, "I can visit anytime. My other relatives visit also. The established staff know me and make me welcome"

We noted that nurses and care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs by attending a religious service. Furthermore, the provider recognised the importance of appropriately supporting people if they chose gay, lesbian, bisexual and transgender lifestyles. A policy to support staff was in place.

Where people were unable to communicate verbally we observed staff were aware of how to communicate with people and understand their needs. A member of staff explained, "I talk to people about their past history." They told us they used cards to communicate with a person who had a hearing impairment." Another member of staff said, "I use good communication. I treat people how I would like to be treated and how I would treat my own family. There is a person here who can only communicate by their eyes. Like blinking or grimacing. I have got to know when they are uncomfortable and want cleaning or needs something to drink."

A complaints policy and procedure was in place and on display in the home. People told us they would know how to complain if they needed to. However two relatives told us they did not feel their complaints had always been addressed in the past. For example, a relative told us, "No I don't know. I would talk to the lead person. In the past I have raised complaint about a lost hearing aid but they did nothing nonetheless." Of the people we spoke with three relative's and one member of staff had raised concerns with external agencies because they felt nothing was being done to address their concerns. We observed the provider was currently dealing with seven complaints at the time of our inspection. The manager told us that previously complaints had not always been responded to within the timescales of the policy.

People's preferences and choices for their end of life care were recorded. Records showed that the staff had consulted with people about how they wanted to be supported at the end of their life.

Inadequate

Is the service well-led?

Our findings

The provider had some arrangements in place for checking the quality of the service. However we saw where issues had been identified actions had not always been put in place. We observed at a recent meeting with staff on the 11 January 2018 this had been raised however the issue had not been resolved. The regional manager was in the process of putting in place a comprehensive system for carrying out quality checks and ensuring actions were taken to resolve identified issues.

The leadership of the service did not demonstrate clear values to ensure people received person centred care. We found that putting people at the centre of the service were not embedded into practice. We observed incidences of care which are detailed in other parts of the report which did not put people at the centre of care.
A registered manager was not in post however the provider had put in place an acting manager who told us they were going to register with us. Staff told us they thought the new manager was 'heading in the right direction' and that they were hopeful things would improve. In addition the provider had recently appointed a regional manager who was providing support to the acting manager. The acting manager told us they were trying to promote a positive culture in the service that was focused upon achieving good outcomes for people.

We found that people were not always given a choice regarding the meals they preferred. People did not always receive the support they required with their care. Risks to people's safety and well-being were not adequately addressed and people did not have access to activities which met their needs and preferences. Staff did not follow recommended infection control procedures. Although the manager told us that staff were supported through supervision, we found that staff did not receive on-going feedback on their performance as supervisions were not completed regularly. Although staff meetings took place the issues raised at these had not been address.
Staff and relatives told us that the manager was approachable. We observed the manager was visible during our visit particularly in Willow where there were a number of new members of staff. The manager had started carrying out a daily walk round of the home to ensure they were familiar with the issues on a daily basis and could were appropriate take action. However one person told us, "On Willow I'm not sure who is in charge now."

People's views regarding the running of the home were not always acted upon. Staff told us that staff meetings had not been held regularly. However we saw recent meetings had been held with heads of department and nurses and senior care staff. The care staff we spoke with told us they did not have regular meetings but would welcome these. Staff said that they felt when they raised issues or made suggestions these had not been listened to in the past but they hoped that things were changing. We observed where issues had been raised action to address these had not been put in place. For example, we saw in the minutes of a meeting on 7 November 2017 with heads of department and in three residents meeting on 2 November 2017 issues regarding meals was raised however on our inspection we still found concerns about the standard of food. The issue of the increased use of agency staff was also raised at this meeting as beginning to be a concern. However we found these issues had continued to be a concern. Relatives we

spoke with were aware of the meetings and told us they were held two or three times a year.

Staff did not fully understand their role within the organisation because many were new to the organisation or agency staff in two of the units, Castle and Willows. The provider did not have systems and processes in place to ensure that staff including agency staff had the appropriate skills and knowledge to care for people appropriately. Permanent staff in the memory unit said they felt supported in their role by local management, for example the nurses and senior care staff. They told us that staff worked as a team in the unit in order to meet people's needs. However they said they did not feel supported by the provider or senior managers but acknowledged there had been recent changes which they hoped would improve the situation. Staff were not consistently working to the provider's policies and procedures and arrangements were not in place to monitor this. Some staff had taken on lead roles such as being responsible for new staff, however due to the pressures on them because of the increased number of new staff they said this was quite difficult at times.

There was a lack of management oversight of the service. We spoke with the acting manager and the regional manager who told us they were aware of some of the concerns we found during the inspection but due to the difficulties in staffing and changes in management systems and process to ensure good quality care were not in place. The failure to identify these concerns and ensure improvements in the service were sustained meant people did not receive safe and effective care in line with their needs and preferences.

We saw policies were in place however some of these did not reflect current best practice or phrases, for example the complaints policy did not include information about access to the health service ombudsman if people were unhappy with the response to their complaint. Instead it referred to CQC who do not resolve individual complaints. The DNACPR policy was entitled DNAR which is the old phraseology and did not reflect current guidance.

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

The provider had not consistently submitted notifications for these. Notifications are events which have happened in the service that the provider is required to tell us about. We checked our records and found notifications had not been submitted to inform us of all the people who were subject to DoLs. Records showed that the registered persons had informed us about accidents and incidents as required by law.

The ratings for the last inspection were on display in the home. However the website did not display the ratings according to guidance. We spoke with the regional manager who told us they would address this as a matter of urgency. At the time of writing this report we have checked to see if this has been carried out and found that the provider is still not displaying their rating according to our guidance.

The service had a whistleblowing policy and contact numbers to report issues of concern, were displayed in communal areas. Staff told us they were confident about raising concerns about any poor practices witnessed.

We found that the service worked in partnership with other agencies. For example a joint improvement plan was in place with the local authority and health partners in order to improve the quality of care. The provider had also agreed not to admit people to the Willows unit until issues regarding staffing had been resolved.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Arrangements were not in place to ensure that where people had their liberty restricted this was in their best interests. Best interests decisions were not consistently in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have systems and processes in place to ensure safe care was provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient appropriately skilled staff available to ensure people received quality care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes were not in place to ensure the delivery of quality care and to ensure the provider was compliant with regulation.

The enforcement action we took:

warning notice