Mr & Mrs B J Wise

St Andrew's Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

St Andrew's Care Home provides accommodation with personal care to a maximum of 23 older people, some of whom are living with dementia. When we visited 19 people lived at the home on the first day. On the second and third day, there were 18 people as one person had been admitted to hospital. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The care home accommodates 23 people in two buildings separated by a courtyard.

The bedrooms in the main house are over two floors and reached by a passenger lift. There are four bedrooms in an annexe; three of which are reached by a stair lift. The annexe is accessed across a courtyard away from the main building.

This unannounced comprehensive inspection took place on 15, 22 and 27 November 2017. It was carried brought forward due to the service being part of a whole home safeguarding process.

When we inspected, the service did not have a registered manager, they had voluntarily cancelled their registration with the Care Quality Commission (CQC) from August 2017. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been appointed on 24 July 2017. At the time of the inspection, they had applied to register as a manager with CQC.

The service was not well led. The service lacked effective leadership and the management style was often reactive rather than proactive. There was not an effective system to regularly monitor and assess the quality of the service and the risks to the people living there. The provider had not demonstrated good practice in the way they had recruited new staff and assessed people new to the service. They had not considered the impact on staff or people living in the home when they admitted a person as an emergency. The provider had not considered the outcome of not funding agency staff during day shifts which had impacted on staffing levels and resulted in two staff working long periods of time.

The provider had not kept people living at the home and relatives or visitors informed of the changes of management. They had imposed charges for equipment without an explanation to relatives or the person involved; they had not overseen how people's personal allowances were managed. This meant there was no audit trail to record transactions and people's relatives had been presented with bills backdated to 2015. They did not make records of their audits available at the service to show how they had judged the environment and people were safe and well cared for.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions, and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection,

there was not a consistent approach to making applications to the local authority in relation to some people who lived at the service. People were not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the systems in the service do not support this practice. People were not routinely involved in their care plans or reviews so their consent was not gained. Best interest decisions were not recorded and documentation linked to lasting power of attorney was not requested. These practices meant people's legal rights were not protected.

Recruitment practice did not ensure all the necessary information was in place before staff started working at the home. We saw examples of kind care, with staff showing affection and compassion towards people. However, there were also practices which undermined people's dignity and privacy. Staff were attentive and positive about their role but some people commented that they could feel rushed by some staff who did not take to time to ensure they understood them.

Safety checks were carried out but the systems in place were not thorough and potentially left people at risk of harm. Laundry arrangements and a lack of guidance around infection control posed potential risks to staff and people's health. A few items of furniture were damaged and the odour in one room had not been addressed in an effective way. Work had taken place to re-decorate areas of the home and the furniture in the dining room had been updated, which people commented positively on.

People were supported to see, when needed, health care professionals. Care staff recognised changes to people's physical well-being and visitors said they were kept informed by staff regarding their relative's health and well-being. The administration and storage of medicines was well managed, apart from for one person, where their prescribed creams were inappropriately stored. People were supported with their meals, where needed, and people's weight and fluid intake was monitored.

During our inspection, we found a number of areas that needed to improve to maintain the safety and well-being of people that had not been identified by the registered manager or the providers. We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have made recommendations linked to the design of the environment, making complaints information accessible and end of life care. You can see what action we have told the provider to take at the back of the full version of this report.

We are taking further action against this provider and will report on this when it is completed. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service.
This will lead to cancelling their registration or to varying the terms of their registration.

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

During the inspection, we contacted the local authority safeguarding team, commissioners, deprivation of liberties team and community nursing team so they were aware of the potential risks to people's safety and well-being at the home.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The environment was not kept safe because hot water temperatures were not regularly checked and action not taken to reduce risk when temperatures were unsafe and potentially put people at risk.

Some staff needed further training in safeguarding so they were clear when to report concerns.

The administration and storage of medicines was well managed, apart from for one person, where their prescribed creams were inappropriately stored.

The recruitment process did not ensure people were cared for by suitable staff.

The laundry arrangements did not keep people safe from the risk of cross infection.

Some shifts ran below their assessed levels, which impacted on people living at the home.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

People's legal rights were not consistently protected as deprivation of liberty
safeguard applications were not always made in a timely manner. People or their representatives were not routinely involved in decisions around care planning and reviews.

Recent staff training provided by the NHS gave staff the skills and up to date knowledge to meet the needs of people living with more complex care needs. Clarity of staff roles overseeing inductions was needed to ensure new staff received a thorough induction.

People were supported to see, when needed, health care professionals.

People were positive about the quality of the food and consideration had been given to make mealtimes a pleasurable experience.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People living at the home and their visitors were positive about the caring nature of most of the staff and the friendly atmosphere. However, some practices undermined people's privacy and dignity as some people felt some staff were abrupt in their manner and rushed them.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Assessments by the provider had not considered the safety of individuals and the impact on others living at the home.

Records were not always accessible in their format and wording, including the complaints process.

Social activities took place regularly at the home.

Work had taken place to update care plans and plans were in place to start monthly reviews.

Is the service well-led?

Inadequate

The service was not well led.

There were ineffective systems in place to monitor the quality of care
provided and keep people safe. The provider had not kept written audits of the quality of the service to ensure people were receiving safe and good quality care.

The provider's practice did not create a positive role model to recruit new staff and admit new people safely.

The provider had not informed people living and visiting the home about changes of management and about a change in charges for equipment. They had not overseen how people's personal allowances had been audited which had resulted in mismanagement.

St Andrew's Care Home

Detailed findings

Background to this inspection

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

This unannounced comprehensive inspection took place on 15, 22 and 27 November 2017. The inspection team comprised of two inspectors on the first and second day and one inspector on the third day. This inspection was brought forward because the Care Quality Commission (CQC) were made aware of concerns relating to the standard of care and the way the service was run. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

People in care homes receive accommodation and personal care as a single package under one contractual agreement. The care home accommodates 23 people in two buildings separated by a courtyard

Prior to this inspection, we reviewed the information we held about the service. This included a Provider Information Return (PIR) which had been completed in 2016. 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. We reviewed the information included in the PIR along with information we held about the home. This included the previous inspection report and notifications sent to us. A statutory notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern. We also reviewed information we received from the community nurse team and the safeguarding nurses relating to specific safeguarding concerns.

We met most of the people using the service and spoke with them about their experience of living at the home. We spoke with five visiting relatives. We looked at four people's care including their care plans. A number of people living at the service were unable to communicate their experience of living at the home in detail with us as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

We spoke with the manager and seven staff which included care staff, housekeeping and kitchen staff. We looked at systems for assessing staffing levels, for monitoring staff training and supervision, staff rotas, and staff files, which included five recruitment files for newly recruited staff and training records. We also looked at quality monitoring systems used such as audits, checklists and the service improvement plan. We liaised with commissioners and health and social care professionals who regularly visited the home.

Inadequate

Is the service safe?

Our findings

The service was not safe.

The recruitment procedure did not consistently ensure that people were supported by staff with an appropriate character. We judged people's safety was at risk because recruitment practices were not safe. The organisation's recruitment policy stated before a new member of staff could start in post: 'At least two satisfactory written employer references have been received for that candidate, including one from the last employer…. And the Disclosure and Barring Service (DBS) is satisfactory.' We checked five personnel files, four showed that new staff members had started before both satisfactory references and DBS had been received. This demonstrated that the organisation's policy had not been followed; people were put an unnecessary risk of being cared for by staff inappropriate to work with vulnerable people.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with four staff who knew their responsibility to report abusive practice either internally or externally. Most staff had completed safeguarding training. However, a fifth staff member was unclear about their responsibilities or how to define abuse. They said they had not received any training in understanding safeguarding, which records confirmed. We were told they had been inducted by one of the providers.

We looked at the records of incidents in the home. In early September 2017 a person had an altercation with another resident and grabbed a wheelchair footplate, which they would not let go of and started swinging it around, which put other people at risk. They were described as "shouting and cursing, punching and hurting." Staff had to intervene to protect people. Staff confirmed a safeguarding alert had not been made to the local authority about this incident and they had not notified the Care Quality Commission (CQC). This indicated staff and the provider did not always recognise safeguarding concerns, which potentially put people at risk of harm.
We met a family member of a person who had moved to the home and had been assessed by the provider. They said they had shared important information with the provider to keep their relative safe from harm from another visitor. They said some staff appreciated their concerns but they were not confident the risk was understood by all staff. We looked at the person's care plan and saw there was no reference to the concern or what should be done to help keep the person safe. A staff member said they lacked time to read care plans and was not aware of potential risks linked to some individuals living at the home. For example, they were not aware that a person demonstrating sexualised behaviour towards female staff showed their mental health was deteriorating and could potentially have an impact on the safety of vulnerable female residents.
These were examples of a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was part of a whole home safeguarding process; the local authority had suspended placements at the home. Safeguarding staff had completed visits to the home to help assess people's safety and well-

being. Social care professionals had also reviewed the care of people living at the home. The service was part of a whole home safeguarding process four years ago flowing concerns linked to poor management and the standard of care, which resulted in significant staff changes. Staff expressed concern that the service was again in whole home safeguarding but said they were committed to make improvements.

Staffing arrangements at the home did not always maintain people's well-being. The manager did not use a staffing tool to determine staffing levels at the home. As a result, the manager was unable to demonstrate how many care workers were needed to be on duty to meet people's care and social needs fully. People living, visiting and working at the home said there had been a recent high turnover of staff. Staff said during the summer this had resulted in them working excessive hours but this was now improving. However, they were concerned that some new staff were choosing not to stay. A person commented on staff in a survey, "They do very well under exceptional circumstances." The rotas showed that the manager and the office manager were working hands-on care shifts to cover staff vacancies. This meant the manager and the office manager had worked 12 days without a day off and working eight hours a day. People said generally staff were available, although several felt there were particular periods of the day when they had to wait longer for a response. There was a new call bell system which had been in place for over a month; response times had not yet been audited.

The manager and staff told us five people regularly needed two staff members to assist them to move safely. Their rooms were on different floors. One person was mainly cared for in bed and needed support to move at night. We were told the staffing levels should be three care staff, which included a senior from 7am to 9am which increased to four from 9am until 2pm. In the afternoon, between 2pm and 7pm there were also four care staff, including a senior. This reduced to three care staff, including a senior, between 7pm and 10pm. Care staff also had to prepare the teatime meal. There were two waking night staff. However, when we looked through staff rotas with a member of staff, shifts were not consistently running at these levels. For example, six morning shifts out of seven were short by one care staff. Rotas showed agency staff were working at least two nights a week at the home alongside a permanent member of staff.

Care workers' annual leave was not well managed. Despite there being advance notice of annual leave, arrangements were not put in place to provide staff cover. Staff said the provider was reluctant to employ agency staff to cover day time shifts but would fund agency night staff. Instead, sometimes the cook or night staff would stay on extra hours to help out. People living at the home told us some staff rushed them. During the inspection, there was a fire alarm test; one person said they had been worried as staff had forgotten to tell them it was occurring so they were worried there was an emergency.

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

There was not a consistent approach to providing information for agency staff. We asked what information what was given to agency staff when they came on duty at the home for the first time. There was no formalised system such as a checklist to ensure key information was provided. A staff member said the agency sent confirmation of the agency member's name, photo and training, as well as their DBS number. Rotas showed the agency staff were often staff who had worked at the home before.

Some aspects of risks to people's safety were not always effectively managed. The environment of the home potentially put people's safety at risk. For example, the temperature of hot water in the home was not routinely monitored or recorded. The last recorded check was 29 June 2017. On the second day of the inspection, we asked a staff member to check and record the hot water temperature from taps on the sinks and baths throughout the home. They sent us these records. The hot water for one bath was recorded as

above the Health and Safety Executive (HSE) recommended temperature. We checked with the staff member to see what action had been taken to address the risk of scalding. Staff said a plumber had been called, but had not yet visited the home. A staff member said they had verbally informed colleagues about the potential risk to people's safety.

Care staff said they had not been told that the hot water temperature for one bath was now unsafe. They said their usual practice was to record the temperature of the bath water before people were immersed. Records showed these were within HSE guidelines. On the third day of the inspection, we checked the hot water temperatures again for this particular bath. We were unable to keep our hand in the water because it was so hot. We used a thermometer and saw the temperature had increased further. It went above the scale on the equipment and was therefore unsafe. We prompted staff to take action to protect people living with dementia from being able to access this bathroom without a staff member, which they confirmed they had completed.

There were not robust systems in place to ensure the home was safe for both staff and people living at the home. For example, a staff member said when they were on shift they walked around the home to check it was safe. They said this included checking hot water temperatures and the location of fire equipment, but none of these checks had been recorded. They had placed dated stickers on the beds where there was pressure relieving equipment. They said this was to show the bed had been checked but they did not have a suitable qualification to make these checks meaningful. During the first day of the inspection, we saw how pressure mattresses had been set at a level appropriate for people's weight but there was not a record of this setting. Staff recognised this was needed to help staff monitor the setting was correct and said they would add this to people's care records. Pressure mattresses which are not set correctly can place people at further potential risk of pressure damage to their vulnerable skin areas.

Rubber matting had been placed across the courtyard to make the surface less uneven for people living at the home who walked between the annexe and the main house. One edge of the matting had risen making it a potential trip hazard; we pointed this out to staff, who said they were aware of it and that it needed to be addressed. A risk assessment for the environment did not include this risk. The risk was reduced because one person living in the annexe chose not to leave the building and the second person was usually accompanied by a staff member. The provider told us the risk had been addressed the day after the inspection.

There were no routine systems in place to ensure equipment was regularly checked to make sure it was safe and in working order. For example, a health care professional had recently prompted staff to organise checks to ensure slings were still safe to use with moving and handling equipment and order new ones, if needed. One wheelchair in a person's bedroom had only one footplate in place. Both a health care professional and relatives had reported this to care staff. Staff told us this was because another wheelchair, which was used more frequently, lacked a footplate so they had 'borrowed' that footplate. As part of the safeguarding process, health care professionals had prompted the provider to have the seated weighing scales calibrated; there had been a delay of several months, but staff said they were now working accurately.

A lack of effective infection control and prevention procedures potentially put people at risk of cross infection. There was no appointed staff member to oversee how good infection control was implemented. The home's infection control policy states "Hand washing facilities will be provided wherever infected materials and/or clinical waste are handled." However, there was no hand washing sink in the laundry room and there was no bin for staff to throw away used gloves. The laundry room was very small and sited opposite the kitchen. There was an offensive smell when soiled laundry was being washed and there was no window which could be opened to reduce the smell or the heat of the room.

The laundry room was cluttered. There was a sign under a bench which detailed what coloured buckets and mops should be used for cleaning different areas or tasks. Staff knew which coloured equipment should be used for the dining room and toilets but were unsure about bedrooms with specialist flooring and gave a mix of answers. There was no sluice in the home. Staff said they emptied commode pots down the nearest toilet; there was no written guidance given to them as to how this should be done in a safe manner to prevent cross infection. A staff member said they used their common sense.

External contractors visited the home to carry out repairs and some safety checks. A log was kept of requests for repairs and a date when work was completed. On occasions there could be delays in work being completed with no specific staff member checking the work had taken place. For example, on the first day of inspection, two fire doors were logged as needing work on them. On the second day of inspection, one fire door still was not fixed; staff said they thought this had been addressed.

On the first day of inspection, we opened the door to a person's bedroom; it made a loud harsh noise. Staff said this had been fixed once already; they said it would be addressed again. Staff said the person was checked by staff throughout the night, we expressed concern with the noise they would have to endure each time they were visited by staff. A week later the door made the same noise; we were told a carpenter was being arranged. Two weeks later the door still made the same noise, although staff said a contractor had visited to oil the door. There was no sense of urgency to address the noise despite the impact it might have had on the individual; the person who lived in the bedroom was unable to comment on the issue.

All these areas of concern were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. They showed us their call bells in their rooms which were located by their bed and adapted to use when they sat in a chair in their room. They knew their purpose, although some said they chose not use them. However, several people told us they had an uninvited person living with dementia who came into their rooms. One person said they did not mind and would call staff if they needed help with asking the person to leave. Another said they had asked for a lock on their bedroom door as the uninvited person could frighten them. They said had been told by a staff member this would put them at risk as staff would not be able to access them. During our tour of the building, we saw another person had a specialist lock which staff could access from the outside in the event of an emergency. We highlighted this inconsistent approach to a staff member who said they would fit a suitable lock.

Records showed that the passenger lift and stair lift were serviced. There had been a period when the stair lift in the annexe had been unreliable but records showed the last incident was 19 June 2017. Staff checked the stair lift was working and now recorded this on a daily basis. Disposable plastic bags were available to store and indicate soiled or infected linen to help eliminate the risk of cross infection. Staff wore personal protective equipment (PPE), such as plastic aprons and gloves.

Most medicines were managed safely. However, one person living with dementia had three tubes of prescribed anti-inflammatory medicine cream on display in their room. We met with them and their relative, who said they had not managed their own medicines for some time. A risk assessment had not been completed to assess if this was a safe arrangement. Other people's medicines were managed so they received them safely. Appropriate arrangements were in place when obtaining medicine. A local pharmacy delivered medicines which were checked in and the amount of stock documented to ensure accuracy. Medicines were kept safely in a locked medicine trolley. The trolley was kept in an orderly way to reduce the possibility of mistakes happening. People were asked if they needed any medicines which were prescribed 'as needed' (known as PRN), such as pain relief. In addition, care plans documented when to give certain

medicines. These ensured a consistent approach was being adopted by staff when considering when PRN medicines were needed. For example, to manage anxiety. Medicine recording records were appropriately signed by staff when administering a person's medicines. Audits were undertaken to ensure people were receiving their medicines as prescribed. The checks also ensured medicines remained in date.

Requires Improvement

Is the service effective?

Our findings

People's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005 in relation to consent. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

We checked whether the service was working within the principles of the MCA; the provider had not followed the requirements in the DoLS. For example the local DoLS assessment team had not received additional information on applications for some of the people living at the home who met the DoLS criteria. People who had equipment that could infringe on their freedom or restrict their movement, such as audio monitoring systems or sensor mats to alert staff to a person moving around their room. They had also not been informed that a number of applications were no longer relevant as the person had died or moved away. There was also a delay in applying for an urgent deprivation of liberty authorisation for one person who was staying at the home on an emergency respite basis.

No records of best interest decisions had been made. Where people lacked capacity, there was no documentary evidence that people's capacity to make particular decisions had been assessed. For example, one person living with dementia had a sensor mat in their room. Staff used this to monitor the person's safety and wellbeing. However, there was no documentary evidence that a mental capacity assessment had been undertaken to assess whether the person had capacity to consent to this. There was no record of a best interest decision about the use of this equipment, which restricted their freedom to move around without being monitored by staff.

Staff had undertaken training on the MCA and DoLS but had not translated this knowledge into their practice. However, relatives had not been asked to show legal documentation to confirm they were authorised to make certain decisions on the person's behalf. This indicated staff did not recognise people could not provide consent on the person's behalf, unless legally authorised to do so.

Care records did not show how people had been consulted about their care. For example, care plans were not signed by people living at the home who had the capacity to be involved in discussions. Most people said they had not been asked to read their care plan. However, one person did comment: "I agree to the care I receive, agreed to my care plan." Some people living at the home had a diagnosis of dementia, their relatives had not been asked to review the care plan and sign on their behalf even when relatives had the legal power to do so.

Since moving to the home, one person had changed bedrooms and from the annexe to the main building. Concerns had been expressed by health professionals regarding the suitability of the annexe for this

individual. Records had not been kept as to how this decision had been made and who had been consulted. Their relative had not been informed of the move until after it had taken place.

As part of the ongoing safeguarding process, concerns were raised regarding some of the decisions made by the provider to change the routines of the home, which could impact on people's choice. For example, people not having a bath at the weekend or being requested to eat their teatime meal in the dining room. Minutes from a staff meeting in August 2017 recorded a staff member had challenged the provider regarding the dining room request; in the minutes it is recorded that the provider "insisted that he had made the decisions and it would now happen."

All these areas of concern were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We completed a tour of the home and visited all of the bedrooms, which were personalised. A number of people said their bed was very comfortable. Most rooms were well maintained; including some with specialist flooring. Two rooms which had been identified as odorous at our last inspection had new furniture and carpets in place. However, on our last inspection we had been told new flooring was being considered for a third room which was also odorous. On this inspection, the odour was so strong in this bedroom that it could be smelt in the hallway. This was despite the bedroom windows being open and air fresheners being used. The carpet had not been replaced and the armchair smelt of urine. Staff were unsure why the carpet had not been replaced; they said the room and carpet were cleaned daily but the odour was entrenched.

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

There was a lack of clarity as to who had the responsibility of overseeing staff inductions. This meant one staff member had not received key training for their role and their name was not on the training matrix. The manager said they would arrange a time to meet with the staff who helped organise the general training, to ensure induction training was discussed and planned. New staff members were not routinely asked for previous training certificates, such as for moving and handling training. They had not had their competence formally assessed to ensure their practice was up to date and safe. However, they confirmed they had spent several shifts shadowing a permanent member of staff. Some staff members had not participated in a supervision session for between five and eight months but this was now being addressed by the manager.

The manager was liaising with the local nurse educator team to ensure staff had access to a range of practical training to complement the electronic training also completed by staff. A staff member kept an overview of training for staff to help keep staff practice up to date. Questionnaires were printed off, which staff completed and were then sent off to an external training company who marked them and issued certificates. Senior staff also had medicine training from a national organisation. People said staff knew how to care for them, for example one person said "They know exactly how to help me."

Some people living at the home positively commented on the appearance of their rooms. Some bedroom doors had a number; photo and a name on it help people identify their room. However, there were several rooms without a number, including one with a sign saying 'private'. With agency staff working in the home, this could potentially cause confusion. People said one person living with dementia became disorientated and went into other people's rooms; a staff member said this was now monitored better by staff and the person discouraged from walking down a particular corridor.

We recommend the providers consult current guidance on the design of environments for people living with

dementia.

Consideration had been given to make mealtimes a pleasurable experience. Music was played; tables had tablecloths and flowers on them, as well as condiments. There were new tables and chairs with seating for four people per table. Most people chose to eat their meal in the dining room at lunchtime. People chatted among themselves and staff were attentive. For example, recognising when people needed additional assistance. Equipment was available to help increase people's independence, such as plate guards and plates with separated areas to allow blended food to retain their flavours. The service had been awarded a food hygiene rating of five which is the rating for 'very good.'

People praised the quality of the food. For example, one person said they used to be a cook and thought the standard of food was very good. Another person said they liked the portion size and the variety. We saw people had a range of meals, including one person who preferred soup. Another person said they usually preferred their meals blended not because of a risk but because this was their preference but for one meal had chosen for this not to happen. We saw the cook had remembered their request. Other people needed their meals blended due to a potential choking risk. One person said the staff were very thoughtful as they had changed the content of their meal in recognition of their medical condition. The cook was positive about their role and knew the individuals they cooked for.

Some people were able to tell us how their health needs were monitored by staff. This gave them reassurance. People told us they could access health professionals such as GPs when they needed to; for example a person was due to see their GP that day. Records showed staff contacted health care professionals for advice. There was guidance for staff to follow for people's specific health needs such as monitoring a person's diabetes. We checked to see how staff monitored people's health and weight. We chose three people's records which showed they were weighed regularly and their weight was stable. Health professionals visited the home daily to deliver community nursing support; in 2017 they have made safeguarding alerts in relation to people's care at the home. However, they also commented in a recent safeguarding meeting that staff worked hard, were willing to learn and followed the advice that was given. The manager had made arrangements for a mobile dentist to visit people at the home.

Requires Improvement

Is the service caring?

Our findings

Some aspects of staff practice did not promote a culture which respected people's privacy and dignity. We asked people for their views on the attitude of staff and how they provided care to them. One person said they were "very good." Another person was reluctant to comment but said they can be "a bit iffy"; we asked for clarification. They said some staff could be abrupt. They said some staff were kind but not all. However, they told us they thought the staff "worked hard." A third person said they had liked it when they first moved to the home but "things feel different now." They spoke fondly of specific staff. A fourth person said the majority of staff were fine but some could be "abrupt and thoughtless." They wondered if this was because they were short staffed. A staff member raised a concern that some staff on certain shifts did not stagger the work so ended up rushing people before the next shift came on duty. A fifth person told us they were very happy at the home and a sixth person said "The staff are very good here. I don't feel like I am on my own all the time...The staff are kind and caring."

A communal toilet, which was used regularly by people using the lounge, had a broken lock. A person told us there had been an incident where a man had walked in on a woman who had been very upset. However, the lock had not been fixed and was not logged in the maintenance record. This meant that their dignity had not been maintained.

A monitor was being used in an upstairs corridor to pick up the sound if a person left their room or if a person in another room was distressed. A second monitor was used in the dining room so these sounds could be heard by staff downstairs. However, they could also be heard by anyone else living at the home and by visitors. We expressed concern that this infringed on people's privacy and dignity and suggested it should be reviewed. Staff were unsure who had suggested this arrangement. There was no documentation in the people's care records to show how this decision has been made or if people had been consulted.

There were staff who were gentle in their approach and listened to people's opinions. One person was welcomed by a staff member as they came out of their room and encouraged to get a hot drink. The person responded well to this attention and solicitously checked if the staff member had a drink of their own. This person responded particularly well to some staff members who knew their previous employment and chatted with them about this role. On another occasion, a staff member noticed that a person's hearing aids were not working well and asked if they could change the batteries, which they did as soon as the person gave permission.

One person's care plan recognised how communication needed to slow and calm for them to be able to follow or they became frustrated. We saw them become irritated as they were unable to take off their jumper; a staff member offered to help and was polite and calm in their manner. They took time to show the person why they were having difficulty and assisted them. The person's care plan stated that the person valued good manners and staff were to ensure they recognised this in their interactions. Their appearance was also important to them and we saw this was reflected in the formal manner in which they dressed. Staff took pride in the fact they had won the person's trust and were now able to assist them with personal care.

Most people looked relaxed in their surroundings and chatted to staff as they passed by them in corridors. A visitor said they "could not fault the girls" when asked about the standard of care at the home. Another said "Everyone is always friendly." Two other visitors commented they had noticed a positive change in how they were welcomed by staff and offered a hot drink. People looked well cared for. Some people told us they received support with a shower or bath depending on their preference. People said they could have the support for the amount of times they requested, such as twice a week. Visitors to the home said they were happy with how their relatives were supported to maintain their appearance. People's clothing was hung neatly in wardrobes and generally packs of incontinence pads were stored discreetly to help maintain people's dignity.

Requires Improvement

Is the service responsive?

Our findings

The provider's website stated that the philosophy of care for St Andrew's Care Home was to "look at the 'Whole Person' and not just part of a person. It is so important to identify each person individually in order to bring the right benefits for them. This can be achieved when having awareness of the following: their physical needs, their social needs, their environmental needs, their emotional needs, their spiritual needs and their intellectual needs." However, the actions of the provider did not reflect this statement.

As part of the whole home safeguarding process, local authority commissioners had originally advised the provider to contact them if they planned to admit a person to the home. This was to ensure the service could meet the person's care and social needs. However, despite this arrangement the provider chose to admit a person as an emergency respite placement on a Friday evening without consulting commissioners. They assessed the person without taking a staff member with a care qualification with them to help judge if they could meet their care needs. They did not consult with staff and arrived back at the home at 5.45pm with the person in their car. Staffing numbers had not been increased in recognition of their admission. By 7pm there were less staff on duty and staff had no prior knowledge of the person's care needs. It also meant they were reliant on out of hours and emergency health services if they could not meet the person's needs as other services were closed for the weekend. The daily care notes for the evening showed the person later became "agitated and worried" and chose to sleep in their clothes. Staff were not told the reason for the emergency admission.

The provider said they based their assessment on information from the person's family but had not consulted with health and social care professionals who also knew the person. This meant the provider was unaware of previous actions by the person which could put other people and staff at risk of harm. Later health records documented the person had been violent towards others as a result of their medical condition.

The only vacant rooms available were in the annexe; the provider's assessment took no account that the annexe was not permanently staffed and did not consider whether this was suitable accommodation. Despite recording in the assessment "Just need to keep an eye on!" On their first night at the home at 1am, the person went into another person's room and that person had to call staff using the emergency call bell. A staff member said the person had more complex needs than the assessment showed; they later moved from the home.

In the minutes from a staff meeting in August 2017, an experienced member of the care staff raised concerns about the impact of the person's behaviour on other people living at the home, which was described as "causing disruption". In the meeting, the provider said the person should be moved to the main building as soon as a room became free as "this should help staff keep an eye on (person) and also the room has an alarm outside which will sound when (X) wanders." This showed that the annexe was not suitable accommodation because of the person's tendency to become disorientated and there were not staff based in this building at night. The person eventually moved to a vacant bedroom in the main house five weeks later where there was more staff presence.

All these areas of concern are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked where the complaints information was kept; it was high on a noticeboard which was not clearly visible. Visitors were uncertain what documentation had been given to them when their relative had moved to the home. None had made a formal complaint. People and visitors said they were not routinely introduced to new staff members. Some staff did not wear name badges to help people identify them. A visitor said photos of staff used to be displayed to help people identify staff but this had been taken down, which they thought was a shame as it had been helpful.

We recommend the complaints process should be clearly displayed and in a format that is accessible to people both visiting and living at the home.
One staff member said that care plans had been neglected earlier in the year by a previous staff member and therefore had not been kept up to date. They said the new manager had quite a task to update them. The manager said they had been working their way through each individual's care records to ensure they reflected their current care needs and their next step was to review them. This was in line with the date for completion on the service improvement plan. Each person had a care plan in place which held some personalised information but lacked information linked to consent and for two people key information relating to a safeguarding risk.
One staff member said the internet signal had been boosted but during the inspection there were times when tablets were slow to upload care information. Staff seemed resigned to the delays. Paper copies had been made as a back up to the electronic care system so staff could still access information if there were connection problems.

During the inspection, we met a person who was cared for in bed. Bedrails were used to reduce the risk of them falling out of bed, and a risk assessment had been completed. The electronic care system flagged up when the person needed to be turned, which would alert staff to this task. Staff said they found this useful, although they could not always enter the time contemporaneously in electronic records if the signal was poor. The person's fluids were also monitored using the electronic system. They were totalled on a daily basis and staff monitored these totals sharing this information in handovers between shifts. We saw these daily amounts fluctuated greatly and we queried the accuracy but staff were confident this was a correct reflection of the person's fluid intake.

Care plans recorded people's hobbies and interests. A visitor said their relative liked to have the newspaper discussed with them but their log of activities did not show this happened. Staff printed off the electronic records for activities which people took part in. However, records showed there was a strong reliance on watching the television as an activity for most people. People were positive about the role of the activities staff member, which included arranging craft sessions, the results of which were used to decorate the home. We heard people enjoying a singing session led by the activities staff member. One person also took pleasure in an impromptu singing session led by another staff member. Some people said they preferred their own company but would participate in activities on their own terms, such as selecting the balls for a game of bingo.

Staff said one person was receiving end of life care. However, there was no end of life plan in place. Their wishes about how they wanted to spend this part of their life had not been explored, and put in place, to ensure these wishes were met by staff.

We recommend the provider consult health professionals specialising in end of life care to ensure care and records are based on current best practice.

Staff were able to describe how they cared for this person and how they monitored their fluid and food intake. Records showed the person received regular support from staff to help keep them safe and comfortable. The person's family said they were kept up to date by staff about changes to the person's health and were pleased with the quality of their care.

Staff said in the future they would make adjustments to make information accessible to people, such as large print for people with sensory loss. However, currently written records were not in this format, the complaint procedure was not written in a clear format and was not written in plain English. Photographs to help people identify staff had been removed, which visitors said was a shame as they were not routinely introduced to new staff. One staff member did not give people time to process information before they asked them the same question. They did not rephrase their wording to ensure the person understood and did not check people could hear them. One person said staff could be abrupt when asked to repeat information.

We recommend the provider consult with professionals specialising in accessible information to ensure care and records are based on current best practice.

Inadequate

Is the service well-led?

Our findings

The service was not well led; the provider had not demonstrated good practice in the way they had recruited new staff and assessed people new to the service. They had not considered the impact on staff or people living in the home when they admitted a person as an emergency. They had not consulted with local commissioners to advise them of the planned admission as agreed as part of the whole home safeguarding process. The provider had not considered the impact of not funding agency staff during day shifts which had impacted on staffing levels and resulted in staff working long periods of time without a regular day off.

The provider did not provide CQC with written records of their quality assurance checks to show how they had judged the environment and people were safe and well cared for. The majority of the home was well-maintained and some areas had been redecorated. However, there was a bedroom where the unpleasant odour had not been effectively addressed. When we last inspected the service, we spoke with the provider about how the quality of their environmental audits. We highlighted the way they monitored the environment was not robust and needed to improve.

On this inspection, we saw most furniture was clean and in a good state of repair. However there were a few items which were not. For example, in one room there was a bedside table with a broken top and a chest of drawers with two broken handles. Staff said they had repaired the handles following our feedback. In another room, the sink surround was broken as was the cupboard door underneath. These examples show the provider had not improved how they monitored the standard of the environment and demonstrated a lack of respect for people's well-being.

The provider had not kept people living at the home and relatives/visitors informed of the changes of management. A meeting had not been held to reassure people about the reason for the changes. The manager said a sign had been displayed in the home to update visitors but visitors we met had not seen it. Some people living at the home were unsure who the manager was and had heard from other staff members that the former manager had left. However, one person knew who the manager was and was positive about their role in their survey response saying they were "happy with the new manager as will come and talk to me."

People were not involved in development of their care plans or their monthly reviews, nor were people who were significant to them. The manager had gathered people's views on their experience of living at the home through a survey, although these were not anonymous as staff helped people to complete them. The responses were positive. We checked an external review site as there were cards available for visitors to complete. This was to see if there had been recent feedback about the service or end of life care but there were no reviews. There were no regular meetings for people living at the home to share their views.

The provider told us in an e-mail they had recently taken a 'step back' from the service by visiting less. Some staff said this was positive as they said in their view their presence de-stabilised the staff team and they made decisions that were not in peoples' best interests. Staff said morale had been low but that it was slowly building again. They said the new manager was approachable and worked alongside them.

There were no records to show staff practice was being observed and no record of a judgment of their competency, although a new staff member said they had worked alongside experienced staff.

All these areas of concern are a breach of Regulation 17 of the Health and Social Care (2008) Regulations 2014.

Financial records were poorly managed. During a safeguarding meeting, the manager explained how they had made relatives aware that people living at the home needed their personal allowances topped up to pay for items such as hairdressing etc. They said relatives had questioned why this was needed when they had provided money to pay for these items. However, they had not been given a receipt for their payment and there was not a log to show how much they had paid. It is unclear what has happened to the money.

People's relatives had been presented with bills backdated to 2015. They queried why there had been a delay of two years to bill them and queried if their relative had received all of the services on the bill because of their poor health. They had not been provided with receipts. We have made the local authority aware of their concerns as Devon County Council was partially funding their relative's care at the home.

The provider said at the safeguarding meeting people had still received services such as hairdressing and they had paid any outstanding bills for these types of services. Financial records relating to people's personal allowances had not been kept; the provider had not monitored how people's personal allowances were being managed.

The provider had imposed charges for equipment without an explanation to relatives or the person involved. We met relatives who were very unhappy at being recently billed for items, such as skin wipes and equipment used to help turn their relative in bed. The charge for this equipment was £200; the relatives had been presented with a total bill of over £400 from a care staff member without an explanation. The relatives said the first time they had formally met with the manager was when they asked to see them to query the bill.

The manager showed us how they had made recent changes to how people's personal allowances were recorded, which included receipts to provide a clearer audit trail.

Staff were unable to locate a copy of the home's statement of purpose. We wanted to see what information was provided to people moving to the home. We looked at the care home's website. The mission statement for the service said "We aim to be a successful and respected care home by putting quality first in everything we do, the quality of care and the environment we offer clients, the quality of our people their training and experiences and the quality of our food and activities on offer". However, we judged there was no effective governance or oversight of the quality of the care and support in the home.

The manager had been working with the local authority quality and improvement team to improve the quality of their audits on the safety and running of the home and had taken on board their suggestions to improve their reporting style. They were also working to update the care plans and carry out reviews. The manager had encouraged staff to participate in training provided by the safeguarding team. Some people could identify the manager and in a survey several people said the manager was "nice and helpful" and "I don't see the managers very often but when I do they seem friendly". Staff had recently been sent a questionnaire by the manager for their views on the service; these were still being collated but we saw the responses were mainly positive. A staff told us the manager was "doing her best" and one commented that the manager was enabling the staff to be a happier group. A staff meeting had taken place in August 2017 with the provider and supervisions had begun after a period without them.

Notifications had been made to Care Quality Commission (CQC) regarding people who had died at the home and who had sustained a serious injury. Other statutory notifications, required by law, were not always sent to the CQC. This meant CQC was not able to effectively monitor the operation of the service. The provider had not submitted notifications to CQC to cover all notifiable events in the home. For example, a safeguarding incident.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents CQC had not been notified of all notifiable events in the home. in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a failure to ensure staff understood their legal requirement to act in accordance with the Mental Capacity Act 2005 for those people who lacked capacity to consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People living at the home were not protected from abuse because there was not a consistent approach to training and staff did not always report abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who lived at the home were not protected against the risks associated with unsafe or unsuitable premises because of inadequate management of risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment procedures did not ensure that people were supported by staff with the appropriate character.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Shifts were not always fully staffed and people said some staff could be abrupt and rushed them.