Firgrove Care Home Limited

Firgrove Nursing 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

Firgrove Nursing Home is a residential care home proving personal and nursing care to 13 people with a range of complex health needs at the time of inspection, including some people living with dementia. The service can support up to 35 people.

People's experience of using the service and what we found
New staff were not always recruited safely. The provider told us an agency had vetted the suitability of two care staff. The provider had not checked the vetting was thorough and satisfactory. The local authority had undertaken investigations relating to 30 safeguarding incidents. Incidents of potential abuse had not been notified to CQC nor were safeguarding referrals made to the local authority by the provider. Some aspects of medicines were not managed safely.

Staff had not completed all the training they required to undertake their roles and responsibilities safely. Systems for supporting staff in their roles had not always been available since the last registered manager left the home.

A robust system of audits had not been established to identify any issues or to drive improvement. The quality of care and the service overall was not monitored or measured. The outcomes of accidents and incidents were not always recorded in detail to prevent similar events from reoccurring or mitigating risks. Medicine audits had not identified the issues we found at the inspection. Notifications which the provider was required to inform CQC about by law had not been received. Frequent changes to the management of the home and staff turnover had a negative impact on the running of the home and on staff retention and morale. People and their relatives were unsure who was in overall charge of the home.

Staff did not demonstrate an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We have made a recommendation that training should be identified and implemented. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; but the policies and systems in the service did not always support this practice.

Staffing levels were sufficient to meets people's needs. There were mixed responses from people and their relatives about the numbers of staff on duty and how they were deployed to ensure people received help from staff when they needed it.

The home was clean, although soap dispensers were empty in two parts of the home and there was no hand cleanser. This put people at potential risk of infection. Lessons were not learned if things went wrong because the recording of incidents and accidents was not completed to a standard sufficient to identify any emerging themes or outcomes.

Because of the high turnover of staff, the consistency of care could not be sustained. However, care was

personalised to meet people's needs. People and their relatives felt staff were kind and caring. People felt the home was safe and that staff treated them with dignity and respect.

People found the choices of food on offer were acceptable and, with one exception, people's dietary needs were catered for. People had access to a range of healthcare professionals and services.

Activities were planned in line with people's preferences and interests. People were complimentary about activities at the home and said these had improved since the new activities co-ordinator came into post. People's communication needs were identified and met appropriately.

People and their relatives were asked for feedback about the home through surveys. Responses were mixed in relation to how people felt about the home.

Rating at last inspection and update
The last rating of this service was Requires Improvement (report published 1 August 2019). Following three breaches of regulations at the last inspection, the provider completed an action plan to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received from the local authority and external health care professionals visiting the home. We liaised with the local authority about a number of safeguarding concerns that had been raised and ongoing issues at the service relating to the standards of care. A decision was made for us to inspect and examine those risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Firgrove Nursing Home on our website at www.cqc.or.uk.

Enforcement
We have identified breaches of regulations in relation to safe care and treatment, staff training and supervision, governance and notifications. Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspection is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within the timeframe, and there is still a rating of Inadequate, for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or varying the conditions of the registration.

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.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below	**Requires Improvement**
Is the service responsive? The service was not always responsive . Details are in our caring findings below	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Firgrove Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by four inspectors, one of which was a medicines inspector.

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

The service had a manager who was in the process of registering with the Care Quality Commission. When the manager is registered, this means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. This included details of incidents that the provider must notify us about. We used information, including information of concern, we had received. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with three people living at the home and four relatives about their experience of the care provided. We spent time observing people and how they were supported by staff. We spoke with the manager, an administrator, a registered nurse, the chef, four care staff and the activities co-ordinator. We also spoke with a GP who was visiting the home at the time of the inspection. We looked at seven people's care records. We observed how medicines were administered and looked at five medicines records. We looked at records of accidents, incidents and complaints. We looked at audits and quality assurance records. We looked at six staff files in relation to recruitment and supervision, training records and rotas.

After the inspection
We continued to seek clarification from the provider to validate evidence found in relation to the recruitment of two staff. The provider sent us evidence that medication competencies had been completed for four registered nurses. We received confirmation that nursing staff had valid PINs with the Nursing and Midwifery Council.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At the last inspection, some improvements had been made in relation to measuring people's dependency levels to identify how many staff were required but there were not always enough staff on duty to care for people safely. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Monthly audits to ensure that recruitment checks were robust for new staff were not effective in identifying shortfalls. We issued a Warning Notice to the provider on 12 June 2019. The provider and registered manager were required to become compliant with the requirements of Regulation 18, according to the Warning Notice, by 30 July 2019.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 18. However other parts of regulation 18 were not met which we have reported on in 'Effective'.

- The number of people living at the home had reduced from 17 since the last inspection, to 13 at this inspection. Staffing levels were adequate and were assessed based on people's needs. The manager told us that due to difficulty in recruiting nursing staff, as a registered nurse they often had to work as the nurse in charge. This meant they were taken away from their managerial responsibilities. The manager said they usually worked two or three shifts a week of 12 hours.
- We asked people and their relatives for their views on staffing levels. One person said, "There aren't enough staff and I have to wait for help sometimes. It's all right at night, the nurse comes". Another person told us, "The staff are always very busy; it's 'full-on'. They don't always come quickly to the call bell. I've heard people shout out because no-one came". Some relatives felt there were enough staff to meet people's needs. One relative commented, "I've always seen enough staff around. [Named relative] never has to wait long when she asks for staff support. I've never had any concerns". Another relative told us, "I've always seen sufficient staff and the quality of the staff is brilliant, even with the turnover".
- Our observations confirmed there were enough staff on duty to meet people's assessed needs. One care assistant said, "There is enough staff for the double-up where people need two carers. Some people can't do things on their own because of health and safety, but we do our best here. Before there were more people, but now we have 13, there is enough staff". Another staff member felt there were enough staff.
- We reviewed staffing rotas from 6 January 2020 until 2 February 2020, a period of four weeks. These confirmed there were three care staff and a registered nurse on duty during the day and one care staff and a registered nurse at night, so there were sufficient staff to meet people's needs.
- We observed no-one had to wait long before their call bell was responded to. At least one staff member was in attendance for people in the lounge/dining area.

● A few days after the inspection, we were told that one core member of care staff had left. The manager said they would make up the shortfall by using agency staff so that staffing levels remained consistent.
● Systems were not always robust to ensure all new staff were recruited safely. Two staff came to work at the home as a result of a contract the provider had with an agency. The staffing rota showed that these two staff were scheduled to work 132 hours between them in the week commencing 27 January 2020. We asked for evidence that checks had been made in relation to these staff members' suitability to work in a care setting. Copies of contracts from the agency were provided which did not confirm what checks had been made. We were assured by the provider that contact with the agency would be made to obtain copies of all the necessary recruitment checks the same day.
● The day after the inspection, this evidence was still not provided, therefore the provider was written to formally requesting the evidence of the recruitment checks undertaken. Assurances were given by the provider that the agency had undertaken recruitment checks but they remained unable to evidence such checks. It could not be evidenced that the necessary recruitment checks had been undertaken including employment histories, references, Disclosure and Barring Service checks, proof of identify and eligibility to work in the UK; this placed people at potential risk.

Records relating to staff recruitment were not maintained. This was breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other staff recruitment files confirmed the necessary recruitment checks had been undertaken. before staff commenced employment. These included checks with the Disclosure and Barring Service which considered the person's character to provide care. References were obtained and employment histories verified. We received confirmation of nurses' PINs after the inspection. PIN numbers are provided by the Nursing and Midwifery Council to validate nursing staff to ensure they are legally permitted to carry out clinical procedures.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Using medicines safely; Learning lessons when things go wrong

At the last inspection, care and treatment was not always provided in a safe way. Some risks to people were not managed effectively and reasonable steps were not always taken to mitigate risks. Some parts of the home had a smell of urine and there was a poor level of hygiene. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection while some improvements had been made, we found evidence in medicines management that the provider was still in breach of Regulation 12.
● Medicines were not always managed safely. We were told of an incident that occurred in December 2019, where one person had been given double the dose of a particular medicine for approximately two weeks. In January 2020, a referral was made to the safeguarding authority by a GP when they realised what had happened. Because the person had received an overdose, tests were carried out to check whether they had come to any harm, CQC was not notified of this incident.
● Medicines were not always stored securely. For example, codes to access the medicines room were written above the door to the medicines room. This meant that anyone could potentially enter the room, in addition to the nursing staff who were authorised and trained to handle medicines.
● When medicines were prescribed 'when required' (PRN), protocols were not person-centred to support staff in the appropriate administration, for example, when to recognise a person was experiencing pain.
● Protocols for administering medicines required for an acute exacerbation of a long-term condition, such as low blood sugar associated with diabetes, were generic and not specific to the person. The risk for one

person was increased and significant, because they had an acute infection in addition to further pancreatic impairment.

● There was no process to encourage the reporting of medicines incidents or support learning following incidents reported within the home, therefore improvements could not be made.

● Observations showed that staff knew people they cared for well, including how they preferred to have their medicines administered, which staff supported. However, this was not always documented.

● Incidents and accidents had been recorded, but these were not completed thoroughly in order to be effective in mitigating risks. For example, actions taken following an incident or accident had been recorded, but the outcome or how similar incidents might be prevented had not.

● The previous registered manager had analysed accidents and incidents that had occurred through monthly summaries, with actions and conclusions clearly recorded. This process had not been undertaken since they left the service in October 2019.

● We asked the current manager how lessons might be learned if things went wrong. They said, "It's sometimes about better documentation. Some events happen. I've not been in this situation before, but [named local authority professionals] have been very supportive'.

● Health and social care professionals were providing ongoing support to the home and had asked the management team to identify actions they would be taking as a result of all the safeguarding concerns. Progress to implement any lessons learned arising from safeguarding incidents was slow because the manager often had to work shifts and provide clinical oversight. This meant they did not have the time needed to make the necessary improvements to prevent reoccurrence of similar incidents.

Medicines were not managed safely. People were at risk of unsafe care or treatment. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records showed that people receive their prescribed medicines and these were administered in a timely manner.

● Risks relating to people's safety had been identified and assessed, with guidance for staff to follow. Care plans included information about people's risks in relation to skin integrity, mobility, nutrition and hydration and moving and handling. These were satisfactory.

● Staff had access to personal protective equipment, such as aprons and gloves, supplies of which were available at various points around the home. We observed staff wore protective equipment as required.

● The home was clean, but soap dispensers in two part of the home were empty. The registered manager said this was an oversight by housekeeping staff and they would make sure the dispensers were refilled.

● The local authority had been informed of incidents relating to poor moving and handling practices by staff in recent months. As a consequence, the authority had arranged for care and nursing staff to receive training in safe moving and handling techniques. Some staff had been assessed in their competency to move and reposition safely. This was work in progress and the local authority's moving and handling advisor continued to work and support staff at the home. Our observations at inspection were that people were moved safely.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of abuse and harm. In October 2019, the local authority had 30 open safeguarding incidents they were investigating. The local authority was investigating 11 of these at the time of inspection. These related to six incidents of people not receiving their medicines, end of life care and seeking emergency support, verbal abuse to three people from a member of staff, and a referral for advice to health care professionals because of unsafe moving and handling practices. We used these allegations to inform what we looked at during the inspection. The provider was receiving support from the

local authority and other care professionals to address these concerns.

● A staff member told us of an incident that had occurred recently where one person had a choking incident. The person's care plan noted they had a delayed swallow and had been assessed as requiring a special diet. They required any liquid to be thickened to level 1 and a level 6, soft and bite sized diet, in line with the requirements of the International Dysphagia Diet Standardisation Initiative (IDDSI). IDDSI is a global standard with terminology and definitions to describe texture modified foods and thickened liquids used for people with dysphagia, a difficulty with swallowing.

● The person had been given a meal containing rice which should have been mashed to bring it to the correct, safe consistency. This was not done, so the person eating the rice had started to cough, with a risk of them choking. The meal was immediately removed and the person came to no lasting harm.

● The chef was aware the person needed a soft diet, but there was no information available to them of which foods to avoid. A senior member of staff confirmed the chef had not received training on IDDSI, but commented since they had worked there for years, they should have known.

● We asked to see the record relating to the incident as this was alleged abuse. The incident had been recorded in that a daily note stated the person was unable to manage their rice and that the meal had been taken away. The incident itself had not been reported or recorded, so there was no evidence to show what had occurred, the outcome, how a similar incident would be prevented from occurring in the future and lessons learned. This put the person at continued risk of receiving a consistency of diet that was not suited to their assessed needs.

● After the inspection, we made a safeguarding referral to the local authority, who later confirmed that the incident met their criteria for safeguarding and would be investigated further. We were informed by the safeguarding authority that the above incident was not an isolated event. On one occasion, for example, documents showed that the person had been given chicken and chips and not the soft diet that had been recommended.

● CQC were informed anonymously about the competency of a member of nursing staff who worked at night, alleging that they went to sleep, so people did not always have night-time checks to ensure their safety. For example, one person had become very unwell and a call was made to 111 for advice and guidance. Staff were told their enquiry would be referred to an on-call GP. A GP attempted to make contact with the home at 10.16pm, but no-one answered the telephone or returned the call. The person was eventually admitted to hospital. We were told that this staff member's working hours would be changed so they worked during the day and their practice could be monitored. This did not happen. The manager said there were not enough nursing staff to enable this change to take place. This put people at risk because the provider could not be assured this staff member was competent to work safely. The local safeguarding authority are investigating concerns relating to this staff member.

Systems had not been established to ensure people were always protected from the risk of abuse or avoidable harm. This placed people at risk. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had completed training in safeguarding. One staff member said, "I would recognise the signs of abuse, such as a person being depressed or sad. I would know if something was wrong. If I saw bruises I would record and report to the nurse in charge. If I witnessed any unkind behaviour I would report it straight away". Another staff member told us, "I would inform the team leader or the nurse if I had any concerns. If anything happened and we didn't report it, we would be in trouble".

● People and their relatives felt the home was safe. One person said, "It is a safe place to live, I don't have any worries, there is always a nurse watching what is going on". Another person told us, "It's definitely safe here. I don't like it here, but I don't have any worries. It is well run and staff know what they are doing". A relative said, "I've never had any concerns about safely, I've only seen a lot of kindness".

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At the three previous inspections, concerns had been noted around staff training, including training not being undertaken by a verified trainer and that staff completed or updated their training. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection not enough improvement had been made and the provider was still in breach of Regulation 18. Staff did not receive all the training they needed to carry out their roles and responsibilities.
● A relative was concerned about the training new staff received. They told us, "They are hoping to have two new carers. I have to hope their induction is good enough. [Named family member] can't convey if they are in pain. They do have patches to control pain, but it's a further worry how new staff will communicate and work with them".
● Staff files contained evidence that new staff completed an induction programme, but not that they had received all the necessary training. This meant they were not fully equipped to ensure people received the care and support they required.

● There were gaps in training completed by staff. For example, not all staff had completed or refreshed training considered to be mandatory by the provider. The manager showed us details of training which was to be provided in the future in relation to diabetes management, nutrition and hydration, care planning and specific health conditions. This training was to be offered to staff by health care professionals following concerns about the lack of training provision.
● Staff had not all been assessed on their competency to move people safely. Staff were in the process of completing moving and handling and fire safety training from local authority professionals because of unsafe moving and handling incidents which were reported. Some staff had completed training in equality and diversity and infection control awareness. There was evidence that some new staff had completed training in various topics during their previous employment at other homes.
● The manager agreed that training for staff had lapsed and added that since there had been a lot of new staff coming to the home, all the training would be reviewed. The administrator at the home had been offered the chance to complete Train the Trainer in moving and handling by the local authority.
● Staff had access to a variety of e-learning training modules and records confirmed that staff had completed some of these. A consultant who was brought in to identify areas for improvement had recommended a clinical training programme and an organisation to deliver training to care staff, but their

suggestions had not been acted upon.
● Staff supervisions had lapsed. A registered nurse told us that they had been trying to cover supervisions, but the new manager would be organising these now. The manager said they had sent out letters to all staff with their planned supervision dates and these would be undertaken at six weekly intervals. The manager explained, "It's about talking with staff to see how they are feeling".

Staff did not receive appropriate support, training or supervision as was necessary to enable them to carry out the duties they were employed to perform. This is a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives felt that staff knew their loved ones well and had sufficient training and experience to meet their needs. However, one relative expressed concern that new staff may not know people well and added, "It's a worry how new staff will communicate with (my relative) and work with them. The staff have been very good at observing changes and ringing me with any concerns". Another relative told us, "All staff seem to understand what Parkinson's is and what it means. They know how to approach (my relative) , as they would respond negatively to the wrong approach. It suggests to me the care planning must be good and shared with new staff. They have worked on moving and handling issues, identified problems and obtained two new hoists, one to remain upstairs as they don't go easily in the lift. I've always seen new staff working with established staff when using the hoist for the first time".
● One member of care staff told us they shadowed experienced staff when they started and this enabled them to get to know people, their care and support needs. Another member of care staff said they helped new staff when they shadowed them. They explained, "I make sure how they do the trays, make drinks, how people are monitored in the shower. There's always two staff when the hoist is used to be safe. It's all included in people's care plans". A third staff member told us of their induction which consisted of four days' shadowing staff and getting to know people. They explained that care plans were accessible on their mobile phones and this provided them with everything they needed with regard to people's routines. We asked the administrator how confidential information about people was maintained since staff had access to care records on their personal mobiles. The administrator said that staff only had access to the electronic care plans whilst they were in the home. Once they went off site, the access was terminated.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● People's care records included capacity assessments where required. Their ability to understand, retain information and the consequences of any specific decision had been assessed. For example, in one care record we read that decisions were to be made in one person's best interests, taking into consideration all their known preferences and choices. Some relatives had lasting power of attorney over their family member's affairs and these were documented appropriately.

● Staff understanding on the principles of the MCA was poor. The list of training completed or scheduled did not show whether staff had completed or updated their training on the MCA. One staff member said they knew who had mental capacity and who did not; they demonstrated a basic understanding of best interests decisions. They had not heard of DoLS or the implications of this for people. Another staff member told us that if someone has dementia they would not have capacity, so their family would make decisions for them. This is not accurate. This staff member knew that some people were subject to DoLS, but did not know what this meant or why DoLS had been applied for. When asked about MCA, a third staff member confirmed they had completed training in their previous employment. They described what they would do if people did not give consent, for example, in receiving personal care. The staff member explained they would try and encourage people if they were refusing care or come back later.

We recommend that the provider reviews staff understanding in relation to MCA and DoLS and arranges training in relation to this from a reputable source.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and support needs were assessed before they came to live at the home.
● There had been no new admissions to the home in recent months.
● Care plans included information for staff on how people's needs were considered, any particular behaviours and risks. People's care and support needs were continually monitored and assessed, so their care plans could be updated when required.
● A relative said, "I think new staff must have good information about people. I see that handovers between shifts take time, sharing information".
● We sat in on a handover meeting after lunch. It was clear staff knew people very well and this was demonstrated throughout the meeting. Each person living at the home was discussed and how they had presented during the day. For example, one person took a shower in the morning and had gone to Holy Communion. They had been walking well. Another person was due to be discharged from hospital that day, so staff were briefed on the support this person would need since they were still a little unwell.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to meet their needs.
● People and their relatives had mixed views about the quality of the meals on offer. One person said, "The food is not very good, it doesn't look nice. I like liver, but when they did it, it was in tiny lumps, not slices". We observed this person appeared to appreciate their meal at lunchtime and afterwards they told us they enjoyed it. Another person commented, "I love the food. The chef is very good and we have a laugh together. I hate fish and he always does a different meal for me specially". A relative told us, "(My relative) has put on weight here. They have talked about their nutrition needs and they obviously ensure the meal is nutritious; they have often said they like the food". Another relative said, "The chef knows all the residents really well and is good at providing individual purpose-built meals".
● The chef told us they planned a four weekly menu and added, "It's a guide as I do other things. It's hotpot today instead of what I planned". The chef demonstrated an understanding of people's dietary needs, including people living with diabetes and people who required a fork-mashable or pureed diet.
● A food diary showed that people had a choice of two options, with the main meal served at lunchtime. Drinks were freely available to people in their rooms and in the main lounge.
● A system of coloured flags had been created which identified if people had special dietary needs, for example, if they were diabetic. These small flags were placed in front of people when their meals were served and helped to ensure people received meals that were appropriate to their needs.
● People were assisted by staff at mealtimes where this was needed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Some areas of care had improved as staff had received training and support from a range of health and social care professionals. For example, following incidents and concerns relating to poor moving and handling practices, new hoists had been purchased and training provided to staff.

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

● A relative said, "They do get the GP involved very quickly if necessary. For example, she had an infection recently and was very quickly on antibiotics. When she had a pressure sore it was treated and cleared up". Another relative told us, "We have just had discussions about my (relatives) hoisting needs. They have arranged for manual handling advisors to come in next week. I've seen how the speech and language therapist has had to be involved and staff have explained about the choke risk. They tell me everything".

● People's care plans showed when healthcare professionals, such as speech and language therapists, GPs and tissue viability nurses had been consulted. Their advice was recorded and acted upon by staff.

● People's oral health had been assessed. Care plans recorded whether people retained their own teeth or had dentures. For example, one person's dental and oral care plan stated they had stopped using their dentures and had been referred to a dentist for advice.

Adapting service, design, decoration to meet people's needs

● The home provided an accessible environment for people, with a lift to the first floor and a garden that was easy to reach.

● Signage assisted people to orient to places around the home, such as bathrooms and toilets.

● The main communal area was designed as a place for people to relax and doubled-up as a dining area at mealtimes. There was another area where people could watch films and DVDs.

● People's rooms were personalised to meet their preferences.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

●There was a lack of consistency and continuity of care. Staff told us there was a high turnover of staff. Some staff had left their employment with little or no notice, so other staff had agreed to work extra hours to make up the shortfall. Staff did not always have time to sit and chat with people. A relative said, "I see staff in danger of being over-worked. There is always a nurse here, but we need enough care staff to cover the full rota". Another relative told us, "Continuity of staff is my big worry and they just can't keep them. Carers always do their best but they are too stretched and don't have the time people need. My relative spends a lot of time in her room and it means they are on their own a lot".

●. People's diverse needs were catered for.

● One person was profoundly deaf and had extremely limited verbal communication. One staff member said, "They can't speak very much, but will tell you what they want. They are a very good lip reader, so does understand". The staff member added that the person used sign language with people from church who had been trained in this. We observed staff communicated with people effectively and involved them in decisions about their care.

● At the time of inspection, we observed that people were treated kindly by staff; staff were prompt in addressing people's needs and were friendly and patient in their approach.

● A relative said, "I feel [named person] is valued here, it feels like home too. I've always seen signs of good care in how they are presented and they are at ease with staff. I see how kindly they treat all people here. I feel they strike the right balance between freedom of choice and prompting people throughout the day. They know people very well". One person told us, "The staff could see I was upset at one time at Christmas and they gave time to be with me. When I am upset they know me and give me space when I need it".

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

At the last inspection in May 2019, people's dignity was not always respected. One person's dignity was compromised because there was a strong smell of urine in their bedroom. Actions were taken to remedy this and at this inspection we saw that people's rooms were clean and fresh.

● People were treated with dignity and respect and had the privacy they needed.

● A relative said, "I've no complaints of how staff care for my relative; it's been spectacularly good. They look after their appearance very well, which preserves their sense of being a (gender)".

● Staff treated people with dignity and respect. We saw staff knocked on people's bedroom doors before entering and that doors were closed when personal care was undertaken.

● People were supported to be involved in all aspects of their care.

● We observed that people were encouraged to make choices, in how they spent their time for example. One staff member said, "People like their own routine and we have to learn how to do things their way. I've had a good brief and I feel confident. I like this job and I like working with older people". Another staff member told us, "In this home the people are not residents, they are like my grandparents. I don't rush them ever, we have plenty of time".

● People were encouraged to be as independent as possible. One staff member told us that sometimes people might forget where their room was located and become upset. They said they would wait with the person until they calmed and then assist them to their room. At lunchtime, people were supported by staff to eat their food and also encouraged to eat without assistance, when they could manage this.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- Complaints were not always used to improve the quality of care.
- The complaints log provided information on various complaints that had been raised and that these had mostly been dealt with satisfactorily. Whilst complaints were written-down and, in some cases, an outcome recorded, there was no clear indication that complaints were used to improve the quality of care. For example, one complaint regarding staffing levels, moving and handling practice and staff responsiveness had been recorded, but there was no outcome to show the complaint had been responded to or the outcome.
- The last complaint logged was at the end of September 2019 and the manager was not aware of any complaints that had been made since they commenced employment in November 2019.
- We asked people and their relatives if they had any concerns and who they would report these to. One person said, "[Named staff member] has always said if anything's wrong, just tell us and we will try to put it right. I am very satisfied with the care and all that happens here. But I've had to keep asking if I can be helped to get up earlier in the morning and it hasn't happened yet".
- A relative told us, "The only complaints I've made have been about toiletries going missing that I've bought and laundry getting mixed up. I've seen them in clothes that didn't belong to them. I and others have raised it in meetings and together we have discussed various ways to address the issue".

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People received personalised care from staff who knew them well, which included their likes, dislikes and preferences.
- People and their relatives, who had people's consent, felt they were consulted and involved in care planning. A relative said, "When we first came, we seemed to have a lot of engagement, then it fell away for a time, but in the last year we have twice been right through the care plan and we have been able to raise any issues. We are as involved as we can be".
- Care plans provided detailed information about people and guidance for staff, but information was not always accurate, for example, with regard to one person's dietary needs. A near-choking incident had occurred because advice and guidance in the person's care plan had not been followed.
- Details included how staff should provide personal care, support with eating and drinking, physical and mental health needs. Daily charts recorded what actions had been taken by staff to provide people with the care and support they needed.
- Care plans were kept electronically. Some plans included information about people's histories and backgrounds, including their likes, dislikes and preferences. Other plans did not hold detailed information and were not person-centred. However, from our observations, it was clear that staff knew people well and

provided them with personalised care.
● We asked staff about their understanding of person-centred care. One staff member talked about a person and their preferences of which staff should provide their personal care, the times they got up and went to bed and their life and past career. The staff member evidently knew the person very well and had developed a good understanding of their needs and wishes.

End of life care and support
● If it was their wish, people could live out their lives at the home. At the time of the inspection, two people were receiving end of life care.
● The local authority was investigating the case of one person who had died in hospital, after they became unwell at the home. There was an allegation that staff had not taken prompt action in calling for an ambulance, resulting in a delay in the person being taken to hospital.
● Where people were happy to discuss their last wishes and preferences, these had been recorded in their care plans. For example, one person who had capacity had made it clear under certain circumstances they did not want to be resuscitated if they had a life-threatening condition.
● Records showed that some people had 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms. DNACPR relates to whether a person should be resuscitated in the event of a cardiac arrest and whether any attempt to carry out this procedure would be worthwhile.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At the last inspection in May 2019, a new activities co-ordinator had just started working at the home. An activities programme that had been planned prior to the co-ordinator starting had not been implemented which resulted in a lack of meaningful activities for some people who were living with dementia.

● At this inspection, a range of activities had been planned with and for people. Nursery school children were visiting on the morning of the inspection and were entertaining people in the main lounge with nursery rhymes and singing. In the afternoon, students from a local college came to sit and chat with people. People were engaging with the activities on offer.
● The activities co-ordinator had worked hard to plan activities for people every day that were stimulating, engaging and enjoyable. They had gathered information about people's interests and backgrounds, so activities could be organised that were tailored to suit people's preferences. Records were completed and recorded when people participated in particular activities. A film club was organised and people were invited to make choices of what they wanted to view. One person had asked to see a war film and the activities co-ordinator helped them to choose from a selection of four DVDs.
● People from a church visited and people could participate in Holy Communion if they wished. One person spent most of their time in their room and liked a particular musician, so their musical tastes had been met and they could listen to their favourite music. Another person had no visiting relatives, so the activities co-ordinator was helping them to organise their room so it was personal to them.
● The activities co-ordinator told us they were familiar with people's care plans and would pass on information to care staff in relation to people's engagement with activities or any concerns. The manager said, "We are lucky to have nursery children coming in. People like a dog who visits and people from the church. We are trying. We have done surveys on what people like and it's more singing. People enjoy cookery and helped stir cake mixture the other day".
● One person said, "I like some of the activities and I can get up when it suits me". Another person told us, "The activities are really good. We bake every Monday and I do art. Every afternoon I prefer to come back to my own room and watch my TV, then I go to bed when I want to, so I enjoy time with the others and time to

myself. I went to film club this afternoon". A relative commented, "The activities worker is very good. She has found my relative likes balloon games, which goes with their past of liking ball sports. [Named activities co-ordinator] invited me to join in life story work with my relative . It was lovely and it made them smile. I've seen [named activities co-ordinator] spending a lot of time with individuals. She takes time to get to know everybody. She has made a big difference bringing more people from outside and introducing animal visits, which have been a big hit".

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were met.
- Communication care plans were completed which recorded whether people could communicate verbally and how staff should adapt their ways of communicating to meet people's needs and preferences.
- In one person's communication care plan we read they were able to communicate verbally in English, that they had a mild visual impairment and required prescription glasses for long distance and reading. We observed staff made sure the person wore their glasses as required.
- Another person communicated through lip-reading, script and sign language. The activities co-ordinator was learning British Sign Language and used this to communicate with the person. We observed a staff member asking the person what they would like to eat. They spoke clearly to facilitate the person to lip read, wrote down for the chef what they understood the person's food choices to be, showed it to the person and received a 'thumbs-up' in confirmation.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

At the last inspection, one of the registered managers had been unable to complete some actions identified as requiring attention because they had been working shifts. An independent consultant was engaged to support the provider by undertaking monthly audits of governance and to develop an action plan. This was submitted to CQC and the provider had complied with the requirements of the conditions imposed as a result of an inspection in 2018.

- At this inspection, a robust system of audits to measure and monitor the quality of care and the service overall had not been implemented. Actions that the consultant had recommended to improve the governance and auditing of the home had not been taken. For example, the implementation of a governance framework to include a resident of the day form, daily nurse in charge report, weekly manager report and a monthly compliance report. A monthly compliance report was completed in November by the consultant, but nothing has been received by CQC from the provider since then. The manager said they had not seen them.
- The consultant had also recommended the water supply be tested for Legionella. The risk of Legionella infection in residential nursing and care homes is increased because of people who may have a lower immune system. Old age also substantially increases the risk of people contracting Legionella disease. The provider had not undertaken a Legionella risk assessment placing people at risk. The consultant was no longer providing support to the home.
- There was a lack of oversight to ensure all checks were satisfactorily completed when staff were recruited. As a result of all the safeguarding concerns, the local authority had formulated action plans and made recommendations to the provider, but these had not been followed. Lessons had not been learned to identify actions needed to drive improvement.
- The culture of the home was not established so could not be embedded into practice. With a further change in management since the last inspection and staff informing us of a high turnover of staff, there was no clear system of values and beliefs to govern how staff in the organisation should behave and carry out their roles.
- Accidents and incidents had been recorded, but there was no evidence to show how lessons were learned or how to prevent a reoccurrence. We read of one incident relating to a person who was found in bed with a bruise and no indication of how this might have been caused. The person's relative and GP were informed and observations made of the person at the time. An action was recorded that the night staff on duty would be spoken to on their return to work. We asked the relative about the incident and they confirmed they had

been contacted and kept fully informed. They were told the bruise had been sustained accidentally and considered this to be probable. The relative told us how the person's bedding had been changed around to avoid similar bruising from reoccurring and they were satisfied the risk had been addressed satisfactorily. The relative added, "But I don't know if the same staff are still here and therefore if everybody knows. I assume the care plan was revised". There was no outcome recorded in the log to confirm what the relative had told us to ensure staff knew how to avoid a similar incident from occurring again.

● The provider's medicines policy was not service specific or based on current best practice guidance as outlined in the National Institute for Clinical Excellence, (NICE) SC1. NICE guidelines are published recommendations that support the safe management of medicines.

● Medicines related competency assessments were not available for all nursing staff who administered medicines. For those that were, learning needs identified as part of the assessment were not documented for action and ongoing review by the manager.

● Medicines audits were completed by the provider. Whilst these were being completed, due to issues found on the day of inspection, we could not be assured that these were effective to identify and address the issues found.

● Controlled drugs were not always recorded in accordance with legislation.

At this inspection, insufficient improvements had been made. Audits were not effective in identifying issues to drive improvement. This is a continued breach of Regulation 17 (Good governance) and is the third consecutive breach of this regulation.

● Care plans were reviewed as needed and people and relatives' surveys had been completed. People and their relatives had been asked about the kind of activities and events they would enjoy, so the activities co-ordinator had planned these according to people's preferences. Fire and safety checks to the premises and equipment were satisfactory.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The manager had taken over a home which was being closely scrutinised by the local authority because of ongoing concerns.

● One of the nurses who had previously managed the home told us it was difficult to make improvements as the home had not been given enough time to implement these, with constant visits from local authority representatives, such as social services and contracts. They said, "They do not necessarily share information with each other, so we are asked for the same thing over again".

● We were informed by the provider/nominated individual that the new manager was in charge of the home. However, this was not clear to people, their relatives and all staff.

● One staff member said, "If there was a problem, I would talk to [named manager] and she is very nice". Another staff member told us, " I know the new manager is trying to improve things". A third member understood a member of the nursing team was in charge of the home. The manager appeared to understand their role and responsibilities regarding the running of the home, but these were not clearly defined. There was no ownership or clarity in relation to who had overall responsibility and oversight of the home, which resulted in ineffective leadership. The manager told us they were in charge of the day to day running the home, but said they did not have access to some of the staff records which were kept locked away in the administrator's office. On different occasions, we asked the nominated individual, administrator and manager for copies of recruitment documents, but no-one was able to provide us with these when requested.

● This 'blurring' of management boundaries impacted on the way the home was managed, and how the quality of care and the home overall could be improved and sustained.

● One relative said, "It's been common knowledge about CQC concerns and management have

communicated regularly, especially about changes of manager. The regularity of relatives' meetings has improved. People have expressed concerns over the high turnover of staff. [Named senior member of staff] has explained why it is difficult and how they are trying to address it". Another relative told us, "I've picked up from the meetings that relatives and some residents are worried about the future of the home. It's not clear who is in charge".

● Regulatory requirements were not understood and notifications that should have been sent to us by law had not been received. For example, we were told of one person's near-choking incident by a member of staff. This incident equated to an allegation of abuse, and met the local authority's criteria for safeguarding. The circumstances surrounding this incident had not been reported appropriately at the home. CQC had not been notified as required.

● At the time of inspection, the local authority were investigating a significant number of safeguarding concerns relating to abuse or alleged abuse. The provider had failed to identify or notify CQC of these incidents. According to our data, only seven notifications of abuse or alleged abuse had been received from 2017 to date.

This is a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● People received personalised care from staff who encouraged their independence. Staff supported people in ways that suited them.

● Some staff did not demonstrate a full understanding of the concept of person-centred care, although they did know people very well and how they wished to be cared for. Information within care plans was factual rather than person-centred. This meant that new staff or agency staff were reliant on finding out about people's preferences and personal histories from people themselves, if they could communicate them, or from other staff. Person-centred care plans should be based on the person's point of view, rather than being task-centred.

● The manager had been in post since November and was in the process of registering with CQC. The manager felt that the support she and the home had received from local authority professionals had been helpful. The manager told us, "We are all meant to be working together to make improvements. Everyone has been quite supportive. If we had another nurse it would be easier and we are trying to recruit".

● The manager had a good understanding of their responsibilities under duty of candour. They explained, "It's being open and honest. If something happens you report it and go through the process. It will be investigated. You have to be open with the relatives too, straight away I try and tell them".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and their relatives were involved in developing the home. Feedback was obtained from people and their relatives about the home. We looked at three responses from people received in January 2020. One person was 'not very satisfied' about the availability of the manager to discuss any problems when needed. Some relatives felt they were not involved in the affairs of the home. However, some feedback from health professionals who had visited the home was positive.

● One staff member said, "Relatives are a bit anxious about the future. One relative was concerned because a staff member bodily lifted [named person] into bed". (It was confirmed to us that the staff member was disciplined and has since left the home, but was not notified to CQC as required.)

● Relatives told us of meetings they had attended at the home. One relative commented, "I've said I'd like to

see more structure at meetings, especially they should start each meeting with minutes of the last, to show what has been achieved". Another relative said, "I went to the last relatives' meeting, but several of us missed the beginning as it started early, without us being told. They email the minutes afterwards and I'm awaiting the most recent. Communication could be better". A third relative said, "They are trying to make improvements. I see admin has improved, but they can't keep care staff. Management have been very open. They realise all the regular visitors talk a lot during visits. We all share a concern about the quantity of staff. They do prioritise morning staffing as a busy time, but at other times it can go down to two care staff plus a nurse".

● We asked the manager if we could see the minutes of the last residents' meeting held in January, but were told these were locked away and we were not given sight of these at the time of inspection. However, we did see copies of staff meetings held in November 2019 and December 2019, one of which related to health and safety at the home.

● Staff provided mixed responses about the management and leadership of the home. One staff member said, "It is well-run here and the care is good. We do our best for them". A second staff member told us, "They look after the staff and residents well. If we are not happy, the residents will not be happy".

Working in partnership with others

● The home worked in partnership with others. Because of a series of concerns and issues at the home, including safeguarding referrals, the local authority had been providing ongoing support, and made regular visits to the home, to help staff make the necessary improvements. However, a social care professional from the local authority said lessons had not been learned to sustain these improvements.

● Moving and handling training had been provided to care staff from local authority professionals. Other training, relating to specific health conditions and management, had been offered or was planned.