Devaglade Limited

Two Acres Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced, comprehensive inspection visit completed on 15, 16 and 21 August 2018.

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

The home is divided into four units. Three nursing units Rose, Lily and Iris and one residential, Fern unit. Rose and Fern units had shared bedrooms as well as single occupancy rooms. At the time of the inspection, there were 70 people receiving nursing care, and 13 receiving residential care.

The service had a registered manager in post. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

At our last inspection on 5 and 6 September 2017, we rated the service overall requires improvement, with inadequate for the key question, well-led. We found breaches of regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements were needed in relation to safe care and treatment, good governance practices and procedures and for sourcing consent from people living at the service.

Following this inspection, we took enforcement action and told the provider they had to send us monthly updates, linked to an improvement plan in relation to safe care and treatment. The required updates needed to cover nurse competency and implementation of training into practice, particularly in relation to medicines management and pressure care. Completion of four weekly audits of medicines management across the home were also required. Where concerns were identified as part of the provider's medicine audit process, the conditions stipulated the need for the registered manager to implement management and contingency plans to mitigate risks.

During this inspection we identified repeated breaches of regulation and ongoing failings in the service's governance systems. We identified areas of concern in relation to staff competency in safe support of people experiencing dementia and complex physical health care conditions. There were significant shortfalls in the assessment and mitigation of risks to people using the service.

The service did not have robust governance processes in place for monitoring standards and quality of care provided. The registered manager and provider did not complete quality audits in areas such as documentation and equipment such as bed rails.

Staff were not consistently implementing training in the care and support of people living at the home.

People's records demonstrated a lack of consistent adherence to the Mental Capacity Act 2005. Concerns were identified around management of people's food and fluid intake, with a lack of meal choices.

Low staffing levels impacted on people's access to meaningful activities and care records lacked detail in relation to people's hobbies and interests. There was not an up to date, daily activity timetable.

People were not consistently treated with care and compassion, and their privacy and dignity was not routinely protected. Staff did not consistently provide person-centred care to people living at the service.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

People did not always receive their medicines when they needed them

Risks to people's safety had not always been managed well, placing them at risk of harm

Staffing levels were not sufficient, and did not reflect changes in people's dependency levels

We identified safeguarding concerns during the inspection

Is the service effective?

Requires Improvement

The service was not always effective

Staff did not consistently adhere to the principles of the Mental Capacity Act or implement this in their practice

Staff were not always assessing people's needs and associated risks linked to their diagnosed physical and mental health conditions

There was a lack of choice and empowerment for people living at the service, particularly in relation to management of food and fluids

Is the service caring?

Requires Improvement

The service was not always caring

Staff did not consistently treat people or their relatives politely, with kindness or respect

Staff did not always protect people's dignity

Staff did not consistently involve people and their relatives in the design of their care plans

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans did not consistently link to risk assessments, with guidance for staff to follow in relation to the management of risks such as choking and prevention of sore skin.

Staffing levels impacted on people's engagement with meaningful activities and involvement with their local community

Staff did not consistently provide person-centred care and support to people

Is the service well-led?

Inadequate

The service was not well-led

We found poor governance arrangements remained in place

There continued to be poor leadership and managerial oversight impacting on the safe running of the service

There remained a lack of quality audits in relation to areas such as environmental risks, administration of medicines, completion of people's daily written records. Where information was collected, this was not analysed for trends and risks

We identified incidents and safeguarding concerns which had not been reported to CQC, this was an area of concern identified at the last inspection

Two Acres 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 was an unannounced comprehensive inspection, which took place on 15, 16 and 21 August 2018.

On the first day, the inspection team consisted of four CQC inspectors, one CQC medicines inspector with an inspector shadowing the medicine inspection and one CQC assistant inspector.

On the second day of the inspection there were two CQC inspectors, one CQC assistant inspector and one specialist advisor nurse with expertise working with older people with care and support needs. On the third day of the inspection the team consisted of two CQC inspectors.

During the inspection we spoke with eight people who lived at Two Acres Care Home and spoke with eight relatives onsite and by telephone after the inspection. We observed care and support being delivered in communal areas including completion of a Short Observational Framework for Inspection (SOFI) on the Rose unit. Inspectors use a SOFI to capture the experiences of people who use services who may not be able to verbally express this for themselves

We spoke with 24 members of care staff including carers, nurses, ancillary staff, the registered manager and provider. We spoke with a visiting Deprivation of Liberty Safeguards Independent Mental Capacity Advocate.

We reviewed 32 people's care records including looking at daily contemporaneous notes, and where applicable, turn charts, food and fluid records, toileting charts and administration of topical medicines such as creams. We checked 54 people's medicine administration records (MAR) and reviewed the medicines management procedures in place. We attended the morning shift handover meetings on the second day of the inspection on Rose and Lily units. We looked at six staff recruitment files as well as training, induction, supervision and appraisal records.

Inadequate

Is the service safe?

Our findings

During our inspection on 5 and 6 September 2017, we found the service was not consistently safe and was rated requires improvement in this key question with a breach of regulation 12 relating to safe care and treatment. This was because, medicines were not always safely managed and recorded.

During this inspection, we found concerns in relation to keeping people safe and inconsistent assessment of risks and care needs. The necessary improvements to medicines management had not been made following the last inspection. We therefore rated safe as 'Inadequate.'

Records were in place for medicine administration with prescribed instructions. However, we found some gaps and discrepancies in the records including for the higher risk anticoagulant medicine warfarin and gaps in records for external medicines such as creams. Incomplete records did not enable the registered manager or provider to accurately monitor people were receiving their medicines safely.

We found that some medicines had recently not been given to people because they had not been available and obtained in time to ensure their treatments were continuous. Staff had not predicted shortfalls in these medicines and taken action to obtain them in time.

Medicine related incidents were not always reported to the manager to ensure they were investigated to help prevent them re-occurring and to promote staff learning. Regular audits of medicines were conducted by the registered manager but they were ineffective at identifying and resolving issues that we identified. This was concerning as the registered manager and provider had been sending copies of the audits to the CQC each month as part of their improvement action plan linked to conditions on the provider's registration following the last inspection.

Members of staff who handled and gave people their medicines had received training and had their competence assessed. However, we observed the latter part of the morning medicine round on Rose unit and noted that while some medicines had been given at a time earlier in the morning, others were given to people as late as midday. This was significantly later than scheduled and so were not given as intended by prescribers. This impacted on the safety of their use.

Safe procedures were not always followed by staff when giving people their medicines. We saw that a nurse on Rose unit was giving people their medicines while carrying a portable telephone to take calls during the medicine round. We did not observe medicines round on Fern unit, but the unit manager told us this took up to two hours due to repeated interruptions. The nurse on Lily unit answered the main door to inspectors while in the middle of completing their medicines round. These are examples of distractions that could impact on safety when giving people their medicines and is poor practice.

For people prescribed skin patches there were additional charts in place to show where on their bodies they were applied but these had not always been completed by staff, therefore staff were unable to accurately monitor if people had had their patches applied as prescribed. When people were prescribed medicines on

a when required basis, such as medicines of a sedative nature, there was insufficient detail about when staff should consider using them after other non-medicinal interventions such as verbal de-escalation and reassurance had been attempted. In addition, records did not always show why these medicines were used or if their use had a successful outcome. For people prescribed pain relief medicines on this basis and who were unable to tell staff about their pain there were no methods by which staff could consistently assess their pain-levels to know when to give them their pain relief medicines.

Records showed that medicines requiring refrigeration had sometimes been stored at temperatures exceeding the upper limit. This could have led to the medicines being unsafe for use. Medicines with limited lives once opened such as containers of eye drops were not always handled in a way that indicated to staff when they were due to expire.

Staff did not consistently complete detailed risk assessments identifying all individual needs relating to people's health and wellbeing. Records showed that staff reviewed care records on a monthly basis. However, these did not always contain sufficient information to guide staff on what they needed to do to mitigate these risks effectively. This was important as agency staff, who may not have been familiar with people's risks, were regularly working in the home. Care records on Fern unit did not cover all risks and support needs for each person, and were not being reviewed since the person's admission. Where risk assessments were in place those risk assessments and other records were not always detailed about people's needs and the actions staff needed to take to promote people's safety.

We reviewed people's repositioning charts and found that people were not being repositioned as often as had been assessed was required. As pressure ulcers can develop very quickly, this presented a concern that the risk to individuals was not always being robustly managed. We found examples of people expressing behaviours that could place themselves and others at risk. Risk assessments were not consistently in place, and we found considerable gaps in completion of behavioural monitoring charts. Incomplete recording did not enable the registered manager or provider to accurately monitor people's behavioural support needs.

Risk assessments did not reflect an in-depth knowledge of each person to encourage participation in their daily routine where able to. Staff on one unit had not recorded people's weights monthly (or more frequently if needed), and changes in weight were not monitored closely and linked to the Malnutrition Universal Screening Tool (MUST), used to identify people, who were at risk of not maintaining a healthy weight. We identified inconsistencies in use of the MUST screening tool and identification of risks, and inaccuracies in the data held by the registered manager for monitoring of weights across the home.

The registered manager told us they completed environmental safety audits, including infection prevention and control. However, we identified environmental risks that had not been taken into consideration. The service did not complete audits and safety checks of equipment such as wheelchairs and bedrails. The home provided evidence of their last electrical safety certificate with checks completed in 2015.

Window restrictors were in place in some areas to maintain people's safety while having the windows open in their bedrooms and in communal areas. However, on Rose unit there were no restrictors in use to keep people safe. We identified additional security concerns on Rose unit as the two entrance doors were unlocked. This was a concern as it enabled members of the public to walk into this unit near people's rooms unchallenged. This risk was not included in the home's environmental risk assessment. We escalated our concerns regarding this to the registered manager and provider, who arranged for key pad entry systems to be installed.

Many people living at the home were living with dementia. We identified environmental risks throughout the

service, including uncovered water pipes, including hot water pipes. Some bedrooms, and communal areas contained furniture such as wardrobes and chest of drawers that we observed were not secured to the wall or floor. This increased the risk of furniture falling or being pulled on top of people. These areas had not been considered as part of the service's environmental risk assessment.

Items the unit managers told us would be of risk to people living at the service included prescribed creams, razors, drink thickener and personal care products. These were not consistently stored securely across the service. We found that kitchen doors, laundry rooms and sluice rooms were left unsecured and unattended with access to risk items including cleaning products, boiling water urns, drink thickener and other items of risk. These products present a serious risk to people if they are ingested inappropriately. We requested for these risks to be addressed as a priority.

People's care records contained assessments of whether they needed to use bedrails to minimise the risk of them falling from bed. These were not specific about the minimum and maximum sizes of these gaps. They did not incorporate advice about assessment issued by the Health and Safety Executive (HSE) or guidance from the Medicines and Healthcare Products Regulatory Agency (MHRA).

One unit had admitted six people in August 2018. We identified that their care records were incomplete, and lacked key risk assessments and care plans for areas including falls management, moving and handling, choking, nutrition and hydration and weight monitoring.

Care plans lacked clear guidance for staff in relation to the level of support some people required with eating and prompting to finish their meals. Where staff identified people were at risk of not drinking enough, fluid charts were introduced. However, we found gaps in recording and the charts did not consistently have a target amount recorded on them for staff to work towards. We identified people were not encouraged to wash their hands before meals, and staff were observed to tear people's sandwiches in their hands before people ate them, which posed potential infection and cross contamination risks.

Staff told us the management team did not share outcomes of investigation findings with the staff team or implementation of changes to practice where possible to mitigate risk of reoccurrence.

We found people were experiencing falls, and the relevant risk assessments were not always being implemented following these incidents to reduce the risk of reoccurrence. Where falls risk assessments were in place, they contained guidance for staff such as 'ensure resident observed at all times.' However, this was not feasible due to staffing levels, and records showed that people were experiencing unwitnessed falls.

The above information meant the provider was in repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not demonstrate a consistent understanding of safeguarding practices and procedures, and recognising types of abuse. From safeguarding concerns identified during the inspection, staff training and the provider's procedures were not consistently followed to keep people safe and protect for risk of abuse.

We identified that five members of staff, including a nurse had recently been dismissed due to being found asleep during a night shift. This incident was not notified by the registered manager or provider to CQC, the local authority safeguarding team or the Nursing and Midwifery Council.

We identified a person who had unexplained cuts and bruising on their arm. We discussed this with the unit manager who was unaware when the injuries had been sustained as staff had not brought this matter to

their attention, no body map had been completed, and no investigation commenced. This concern had not been reported to the local authority safeguarding team.

We identified a person with a serious skin ulcer, that was assessed to be of a grade that would be notifiable as a safeguarding concern. Staff had not put care plans and risk assessments in place relating to the management of this ulcer and had not notified CQC or the local authority safeguarding team.

We were unable to source assurances that staff and the management team were routinely following safeguarding policies and procedures to ensure people living at the service were being kept safe.

The above information meant the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From speaking with staff and reviewing rotas for the four weeks leading up to the inspection, we identified there were insufficient staffing levels on shifts to meet people's needs. Rotas highlighted a high use of agency staff and variable staffing levels that were not linked to assessed risks and needs on the units. We identified times where staff were being moved and shared between units to meet shortfalls. Rotas showed the home had introduced additional staff to assist with meal times on Lily and Iris units, but rotas indicated that these staff were not on shift each day. Staff told us they worked as a team, but said there were regularly times with not enough staff on shift.

We identified concerns in relation to the implementation of training into practice. We identified unsafe moving and handling techniques repeatedly used by permanent and agency staff observed during different visits to Lily unit. Staff were observed to physically pull people under their arms to move them from a seated to standing position. Once standing, staff were observed to take people's weight to stabilise them, and on one occasion, sourced assistance from a visitor to move the person's feet to enable them to complete a ninety degree turn from their chair to a wheelchair. Staff did not consider people's abilities to transfer safely, and identify when equipment was needed to keep staff and people living at the service safe.

People living on Iris, Rose and Lily units, had individual dependency assessments completed, which were reviewed monthly. However, we identified that the dependency needs of people living on Fern unit had not been fully assessed. We identified that the management team were not reviewing collective dependency needs on each unit when considering new admissions to the home, and were not taking staffing levels and environmental risks into consideration.

We observed people asking to go to bed repeatedly, or asking to go to the toilet, with staff telling them they could not assist as there were insufficient staff in the lounge. We observed a person asking to go to the toilet, and over two hours later they still had not received staff support to do so.

The above information meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two Acres Care Home was visibly clean throughout, with no unpleasant smells or odours identified. Housekeepers maintained cleanliness throughout the care environment. Staff accessed aprons and gloves to use when completing personal care with people to reduce risk of cross contamination or spread of infections.

Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification, information about known allergies and medicine sensitivities and written

guidance about how people preferred to have their medicines given to them.

For people with limited mental capacity to make decisions about their care or treatment and who would otherwise refuse their medicines, the service had consulted with and obtained written guidance from GPs, and pharmacist about how to give the person their medicines crushed and hidden in food or drink (covertly). Oral medicines were stored securely for the protection of people who used the service.

Employment records examined contained references, copies of proof of identity documents and Disclosure and Barring Service (DBS) checks (which helps employers make safer recruitment decisions and prevent unsuitable people from working with people vulnerable due to their circumstances) were undertaken before new staff started work. This helped to ensure people's safety by employing staff who were suitable to work in the care sector.

Each person had a personal emergency evacuation plan in place for use in the event of an incident such as a fire. These contained clear guidance for staff and recognised risks for example of people living with dementia, that they may be unable to respond to risk and emergency situations, therefore requiring support from staff.

The registered manager and provider told us the onsite maintenance and housekeeping team completed regular legionella water temperature checks, flushing of the water system and descaling items such as shower heads, however, no evidence of this was provided on request.

Staff demonstrated understanding of accident and incident reporting procedures. We saw examples of investigations completed post incident by the registered manager and the written responses provided.

Requires Improvement

Is the service effective?

Our findings

During our inspection on 5 and 6 September 2017, we found the service was not consistently effective and was rated requires improvement in this key question. This was because people's mental capacity was not always fully assessed appropriately for specific decisions and best interests meetings were not always completed or recorded. These concerns resulted in a breach of regulation 11 relating to the need for consent. People received enough to eat, but there were not systems in place to ensure that people always drank enough.

During this inspection, we found staff did not consistently adhere to the principles of the Mental Capacity Act 2005. Staff did not offer people choice and control into aspects of their care including food and fluids. We have therefore continued to rate effective as requires improvement.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We noted that there was no contingency plan or information available for those people living on locked units who were not subject to DoLS to ensure they were aware of their rights if to leave the units if they wished to.

We noted examples where relatives had signed consent for some people to be photographed for their care records and to receive personal care. However, this was without evidence that those relatives were legally authorised to take such decisions about health and welfare, for example by having Lasting Power of Attorney (LPA). For one person we did find a copy of an authorised LPA where the relative had signed consent, but the LPA was for finances and not for health and welfare decisions.

Care records did not consistently contain decision specific mental capacity assessments. Where there were concerns about capacity the information was largely used as a tick box list to show that the person did not have capacity to make routine decisions and choices in a range of areas, rather than decision specific. An example of this was where staff had implemented use of pressure mats and door sensors to monitor if people got up during the night, but had not completed associated capacity assessments linked to this decision.

Some staff spoken with explained how they sought people's consent and cooperation to receiving their care. They recognised that sometimes this may take time, or different staff to approach people, and the need to act in people's best interests. However, from observing staff interaction and language used when asking people to follow instructions with people living at the service, this was not a consistent approach

taken by all staff.

The above information meant the provider was in repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had changed how they provided meals for people living at the service, with the decision that people would have a light lunch, and their main meal in the evening. We were told this was because people were eating a big breakfast and then not hungry at lunchtime.

We asked people what they thought of the food. One person told us, "Yes, the food is good." They went on to tell us about the cooked breakfasts they could have. Another person told us, "I had a good lunch." However, they went on to say that the main meal, which was served later in the day was too soon after lunch. They told us they would have preferred their main meal to be later. They were served a mashed vegetable and chicken casserole just after 4.30pm, while we were present. They were not offered a choice before being presented with their meal.

We found examples of people at risk of malnutrition but assessed as low risk, but their health and dietary intake had deteriorated significantly without any indication of their risks being reviewed and updated to reflect changes in their presentation. However, we did find some examples of onward referrals to dieticians, speech and language therapists for specialist advice and assessments. We identified that the kitchen staff fortified every person's food with additional calories, rather than this decision being linked to individually assessed needs and risks which could pose a risk to individual's health.

Staff were expected to monitor people's food and fluid intake. A staff member told us that the nurse on night duty collated this information each day and checked people's intake. They told us that incoming shifts would receive information about this together with the need to prompt and encourage specific people who were not eating or drinking well, this was confirmed when we attended the shift handover meetings.

We observed mealtimes on all four units and found that these were not well organised. Staff brought lunch onto one of the units just before 12 noon and took people to tables. Some people waited seated at the table for an hour and a half before they received their meals and staff assistance to eat them. The lunchtime hot component of the meal was soup. This arrived in a saucepan covered with foil but not otherwise insulated, and sat on the serving shelf or trolley for almost an hour before some people received assistance. We checked the heat of the saucepan and found it cool to the touch. The soup ran out on Rose unit before everyone had been served. There was not enough soup to encourage people to have a second portion. Staff told us soup never usually ran out however, there was a list of how many people lived on each unit so greater consideration was needed.

We saw that pudding ran out on Rose unit before the last people were able to be offered it as an option. Those without pudding were assisted with yoghurt but were not offered a choice of flavour. No one on Rose, Lily or Iris units were offered a choice of sandwiches, which was the main component of the meal.

We noted that the menu pinned on a noticeboard contained three weeks' worth of meal options. We checked it for lunchtime options on all three Wednesdays, the day of our first inspection visit. This showed that soup was on offer for each of the Wednesday menus with another option in addition to sandwiches. The menu listed this on one week as ravioli, another pizza, and on week three, sausage rolls. None of these items was offered as an alternative to sandwiches on the first day of our inspection.

We observed people being left with drinks out of reach, and examples of people not being prompted by staff

to take drinks during their meals. Many of the people living at the service would be unable to request drinks and may not recognise when they were thirsty. On Lily and Fern units, there were insufficient portable tables, so one person was observed to have their drink placed on the seat of a chair, and they ate their soup held up against their chest, which if hot, could have risked scalding their skin.

Pictures of food were not available to use with people to explain what they were being given to eat, and staff did not use plated up meals to assist people to make decisions. Meals lacked choice. Dinner was one meat and one vegetarian option and the presentation of the food did not look or smell appetising. The evening meal on the first day of the inspection included mash potatoes. This was served on white plates, making it difficult for people to see and differentiate items on their plate for example if they had visual impairments, or difficulties linked to their dementia. Food temperature was not being checked before meals were being served. We saw the hot pudding for the evening meal being left on the side in the kitchen, and bowls of porridge were on a trolley with catering film over them to keep them warm in the morning ready for staff to serve breakfast.

Due to a lack of staff on shift, people waited a long time to be given their food or to be assisted to eat it, impacting on the overall dining experience. For people who found meal times stressful or lost interest in eating if the food was not placed quickly in front of them, the time delay impacted on people's food intake and enjoyment of having a meal.

The above information meant the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Data provided by the registered manager and provider did not contain details to confirm completion of annual appraisals and this information was not recorded in staff employment records. Supervision records showed staff received supervision every two to three months. Supervision offered staff the opportunity to discuss their work, receive feedback on their practice and identify training and development needs. Staff told us they received supervision and felt well supported, although there was less clarity about how often the provider expected formal supervision to take place and this was not stipulated in the home's supervision policy.

Some unit managers told us they felt unsupported by the registered manager and provider, and that they needed more support to develop their managerial skills while running the unit.

Nurses and care staff completed the provider's mandatory training through on line and face to face sessions, including moving and handling, safeguarding adults, mental capacity and deprivation of liberty safeguards. Nurses completed specialist training in areas such as injection techniques, catheterisation, wound care and medicines management. New staff completed the Care Certificate as part of the induction process; the Care Certificate is a set of induction standards that care workers should be working to. From reviewing care records and observations of staff working with people living at the service, we identified concerns in relation to the consistent implementation of training and competencies into practice.

The GP visited when required, with provision through two local practices. People accessed chiropody and visits from physiotherapists to provide treatment programmes in the management of issues such as falls as required. The home had wheelchair accessible vehicles to enable staff to support people with attending hospital appointments.

A relative visiting the service told us that they felt staff kept them up to date about their family member's health. They said that they had been included in discussions when the person's doctor visited so that they

could better understand the person's health and what was happening to them.

Two relatives told us they did not feel concerns and complaints were consistently listened to or acted on. Standards of care were felt to vary dependent on which staff were on shift, and the experience of agency staff used, this impacted on their knowledge and understanding of people's care needs.

People's records showed that staff sought advice on their behalf about their health and welfare. We found that there was information showing people received support from their doctor, dietician, speech and language therapy and chiropody services. We saw that there was reference to the dementia support team where staff might need specialist advice to support people effectively.

We found a specific assessment in relation to a person who was assessed as lacking capacity to make informed decisions about taking their medicines. This showed the involvement of a nurse at the home, the person's doctor, consultation with their next of kin and the name of the pharmacist involved.

The units were level access throughout with wide doorways so that staff could assist people who needed mobility equipment. There were level access shower facilities in place. We noted that many people did not have access to baths. Communal bathrooms containing baths on Iris and Lily units, were being used as storage rooms with items in and around the bath, indicating these rooms were not accessed regularly for their intended purpose. One nurse told us that no-one had asked to use the bath in the four years they had worked at the home. The service only provided a maintenance certificate for the bath on Fern unit. People therefore did not have choice and person-centred care in relation to completion of their personal care needs.

Some units had access to outside space, and the site had outdoor seating areas for people to access with staff or family support. We noted that some paths and courtyards were unevenly paved, increasing risk of falls.

We found some seating to be low making it difficult for people to transfer in and out of. Lily and Iris units lacked items of stimulation and interest such a pictures, literature and items for people to interact with or use as a source of discussion for example with staff.

Requires Improvement

Is the service caring?

Our findings

During our inspection on 5 and 6 September 2017, we found the service was not consistently caring and was rated requires improvement in this key question. This was because staff were compassionate and reassuring towards people, but the systems in place did not always ensure that people received a caring service.

During this inspection, we found people and their relatives were not consistently treated with care, compassion, kindness or respect. The approach to care taken by some staff impacted on people's dignity and quality of care. We have therefore continued to rate caring as 'requires improvement.'

From observations of staff interaction with people, staff did not consistently treat people and their relatives across all units with dignity, care and respect and were not consistently familiar with each person's care and support needs and preferences. For example, during one incident, we overheard staff arguing in front of people living at the service and their relatives. This is unprofessional. On another occasion, a staff member announced loudly to the whole lounge that some people had been incontinent. We observed times where staff were abrupt and rude to relatives and visitors. Relatives told us staff on one unit regularly spoke to them rudely. They told us that when they asked questions such as if their relative had had their teeth cleaned, staff responded by telling them if they were unhappy they could do it themselves.

We saw some staff position themselves over people rather than speaking with them positioned at eye level which appeared threatening and intimidating in approach. Staff did not consistently use language and communication techniques suitable for people living with dementia. For example, staff asked multiple, open questions and did not offer people time to answer. We heard staff speak unprofessionally to people. An example of this was where a staff member asked a person, "[Name] move your butt." We were therefore not assured staff treated people with dignity and respect.

Staff did not consistently offer people reassurance and emotional support when they showed signs of distress or feeling unwell.

Relatives gave examples of where people were showing signs of needing to access the toilet and visible signs of discomfort, yet staff told them to sit back down increasing their risk of incontinence. This did not offer us assurance that people consistently received compassionate and dignified care.

Relatives gave examples of visiting frequently, yet not being offered a hot drink, and taking their own drinks to have during the visit. Staff were not consistently offering relatives emotional support.

The registered manager and provider sourced relative and staff feedback by sending out postal questionnaires. We identified that while there was positive feedback, staff had not submitted any responses and some relatives gave negative feedback. Where negative feedback had been received, there was no action plan shared with the inspection team to reflect action taken as an outcome of feedback received as a means of working collaboratively with people and their relatives to improve the service.

Staff did not consistently support people to maintain choice, control and involvement in their care and treatment. Care records did not consistently demonstrate that staff discussed care plans with people and their relatives to ensure incorporation of opinions into the development of their plans. One relative told us they were given forms to sign linked to sections of a person's care plan they had not been involved in developing, and could not understand why they were being asked to sign it.

People had personal effects in their bedrooms. We noted that music playing on the televisions on Lily and Iris unit was modern music chosen by staff rather than people living at the service. Relatives told us that when musicals were played, they had seen people singing along, but this rarely happened. People were not encouraged to maintain personal hobbies and interests. We noted that the television programme showing on one unit was of a frightening nature, and could have caused people anxiety, but this had not been considered by staff.

People used walking aids and mobility equipment such as wheelchairs. Staff hoisted people in communal areas and did not take action to maintain their dignity. This resulted in people being hoisted in skirts, with their underwear on show to others seated in the lounge.

People were not encouraged to access and integrate with the local community with support from staff to reduce social isolation, and maintain skills and independence where appropriate. Staff did not consistently support people to maintain their personal appearance and presentation, or encourage people to make their own clothing choices. We noted that some people had photographs outside their bedroom doors to aid recognition. However, these photographs were not always flattering, and were taken for example where people had sustained facial injuries. The person may not recognise themselves in that condition.

Staffing levels were not consistently in place at busy times during each shift such as during the morning and at meal times to ensure people received the required level of time to complete personal care tasks thoroughly, and to enable staff to spend quality time with each person.

We asked staff if they had time to spend chatting to people. They said that they would try and find time but were often very busy. We saw that some staff engaged warmly with people when they were passing. However, our observations were that people who were more able to express themselves received more interactions with staff.

We noted that, during our formal observations, staff had little time to spend engaging with people other than when they needed something doing, contributing to a task-led approach to care. During the 45 minutes we monitored four people, staff only interacted with people when they were completing tasks. For example, a nurse engaged with one person only when they were administering a medicine. With another, one staff member intervened because a person was not sitting safely in their chair. They offered the person reassurance while they waited for two colleagues to hoist them into a better position. A staff member spoke with a third person only when they were clearing away their lunch plate. These interactions were however, polite and respectful.

However, the fourth person received no staff attention at all during this time, despite a pillow placed to their left in their chair having slipped and being partially across their face. Despite approaching a person sitting close by, staff did not promptly address, or perhaps did not notice, what had happened with the person's face and their pillow.

On two occasions we observed a person was calling out, "Help me please" from their room. Our observations were that they did this each time they heard footsteps pass their room. However, we noted

that there were two occasions when staff walked past their open bedroom door without stopping to engage them or check what they needed.

Care plans took into account people's abilities to express themselves. However, we saw that, for people living with dementia and who needed assistance, staff offered explanations very rapidly.

We observed that not all staff tried to engage with people, talk to them about their meal, or otherwise try to encourage them. We saw that one person was assisted with their soup, drink, and yoghurt without any interaction from the staff member supporting them.

There was variable practice in respecting people's privacy. We noted that staff closed people's bedroom doors when they were assisting with them with personal care. However, there were occasions when they did not knock on open bedroom doors before they entered people's rooms.

The above information meant the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person living in the home told us, "The staff are good. I have no complaints about them." A relative spoke of feeling welcomed into the home and supported by staff. They said, "Everyone is so friendly. They do all they can."

Requires Improvement

Is the service responsive?

Our findings

During our inspection on 5 and 6 September 2017, we found the service was not consistently responsive and was rated requires improvement in this key question. There were not always staff available to ensure that staff had time to spend with people in order to meet their needs and deliver individualised care.

During this inspection, we found concerns around staffing levels and ability to respond to people's needs in a timely way remained. Care records were not consistently written in a person-centred approach. We therefore continued to rate responsive as 'requires improvement.'

Staff did not consistently write care plans collaboratively with people and their relatives. Plans were not consistently person centred and holistic, and did not always incorporate areas of personal importance such as people's protected characteristics such as sexuality and personal beliefs. Care plans did not consistently link to risk assessments, with a lack of accurate guidance for staff to follow in relation to the management of risks such as falls, choking and pressure care. Care plans did not consistently indicate people's individual preferences for showers or baths, with communal bathrooms on Iris and Lily unit being inaccessible as used for equipment storage. The service used a high level of agency staff, unfamiliar with the needs of each person. Care plans therefore needed to provide detailed information for agency and new staff to follow. Many of the people living at the service would be unable to share this information if asked by the staff.

We identified a person with a skin ulcer that required use of a pressure relieving mattress, however, their care plan indicated they regularly became distressed when in bed. The guidance was for staff to assist the person into a comfortable chair in the lounge. Staff did not put pressure care in place for use while seated in the chair. Following our inspection visits, we asked the registered manager and provider to put care plans and risk assessments in place in relation to the management of their person's skin ulcer. Part of the plan was for the condition of the ulcer to be checked daily, and any deterioration to be reported for example, to the GP, and for prescribed cream to be applied twice a day. On day three of the inspection visit, we were unable to locate records of the daily condition checks or cream being applied. We asked the nurse on the unit and they were unable to provide the records. We asked the registered manager and provider for copies of the records following the inspection visits, these were not provided. We therefore were unable to source assurances that staff were consistently responding to the risks and medical advice sourced in relation to this person's care.

People did not have access to meaningful activities in groups or on a one-to-one basis, and there were no regular, planned trips out or integration with the local the community. This was consistently noted across the three days of inspection completed.

The service had received nine complaints between January 2018 and the date of the inspection visit. Information from complaints, and outcomes from investigations were not routinely discussed with staff during unit meetings to reflect on areas of service improvement.

Most people had care plans in place indicating their wishes and preferences when needing care at the end

of their life, however there were considerable gaps in recording of this information for those people living on Fern unit. There were two people receiving end of life care at the time of the inspection on Rose unit. We noted that key care plans were not in place, these were for use of the syringe driver, pain management and positioning. Where care plans and risk assessments were in place, these were not routinely updated to ensure documents gave accurate reflection of current and changing needs.

There were six new admissions on Fern unit in August 2018. The unit manager identified that no pre-admission checks such as weights, dependency levels, body maps, people's likes and dislikes had been completed to enable staff to respond effectively to people's needs. We noted that people who had been residing for longer on Fern unit had very limited information recorded.

Care records across the home were not consistently reviewed and updated following incidents and changes in people's presentation. Where risk assessments were in place, the level of risk was not consistently updated to reflect changes in condition and behaviour. We noted, that this information was intended for use to share with external professionals such as the dementia support team, therefore a lack of recorded information did not provide evidence to support funding and specialist assessment requests linked to changes for example in behaviour and associated risks.

The above information meant the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative visiting the home told us that they had no complaints about it. They were confident that, if they had concerns these would be addressed. Another relative told us that they felt welcome to spend time with their family member at any time. Two relatives told us they did not feel concerns and complaints were consistently listened to or acted on.

For another person, their records reflected what had been important to them in the past, including their appearance and how they had always liked to look smart. We saw that, despite being cared for in bed, their hair was clean and brushed. Their relative told us that sometimes staff could be a little late assisting the person with their wash or bed bath, but they had no concerns about the standard of personal care offered by staff.

One person told us, "I go to sleep if I don't do anything. There's not much time [for staff] with people." Another person said they felt this was the case and that they read a lot because, if they didn't, they would fall asleep. They were experiencing some difficulties with their hearing aids. We heard staff saying earlier in the day that they needed to contact their supplier to check about batteries. However, these remained on the person's table next to them so at risk of being lost. They told us that they thought staff would sort it out "eventually." In the meantime, they were not able to engage in communication unless staff spoke clearly and visibly in front of them, when they told us they could lip read. They could not hear the television.

From our observations of care provided, and information in care records, we saw examples where a person had to wait over 30 minutes to be assisted to get up (from when they had asked). Personal preferences for when people wanted to get up were not consistently recorded in people's care records. We found some communal clocks were set at the wrong time, which could impact on people's recognition of time, particularly if living with dementia.

Inadequate

Is the service well-led?

Our findings

During our inspection on 5 and 6 September 2017, we found the service was not well-led and was rated inadequate in this key question. The provider had failed to make and sustain improvements, and had not fulfilled their action plan. The registered manager and provider had not always informed us of notifiable events. Systems in place for monitoring the service were not effective.

During this inspection, we found that the service remained non-compliant with conditions placed on the provider's registration since the last inspection. Governance arrangements in place were not robust. We therefore continued to rate well-led as 'inadequate.'

The registered manager, provider and designated members of staff told us they completed quality audits including for medicines management and infection, prevention and control however, we identified concerns not picked up through the audit process in relation to medicines management. This is particularly concerning, as these audits linked to conditions placed on the provider's registration from the last inspection.

Unit managers collected information on people's weights, wounds and skin condition and fluid intake and incidents of falls and submitted this information to the registered manager. This arrangement was only in place for Iris, Lily and Rose units, even though Fern unit had been admitting people for over a month. From discussions with the registered manager and provider, we identified that whilst information was being collected, the management team were not analysing the information for trends and risks to improve the quality of care people received.

From reviewing the information collected, there were inaccuracies in the data held which had not been recognised or acted on to address. Information was not being collected in its entirety. For example, a log was kept of wounds and ulcers, there was a box on the log to indicate that equipment was in place, but no checks to make sure the equipment was meeting the needs, and no checks or audits of the records kept for staff completing turn charts, to reduce and improve the condition of sore skin and ulcers.

The serious skin ulcer identified during the inspection resulting in a safeguarding referral being made by CQC, was not logged on the copy of the wound audit information provided by the management team during the inspection. We reviewed their care records, and a level of wound had been present since the person had been admitted three years before, but this risk along with the lack of care plan in place had not been identified due in part to a lack of quality checks of documentation and audit completion. Nurse management and competency in relation to pressure care was an area of concern linked to conditions placed on the provider's registration from the last inspection.

The registered manager and provider did not audit or spot check the quality of records including daily contemporaneous notes, turning charts, food and fluid charts or toileting charts, therefore gaps in recording identified during the inspection had not been identified by the management team or measures implemented to address. The management team did not spend time observing care delivery in communal

areas. The registered manager and provider were unable to give us assurances that people were receiving the levels of care required to keep them safe and well.

The home was in the process of implementing an electronic documentation system. The management team were confident this would address the issue of gaps in recording as the system generates alerts. However, this system was not in use at the time of the inspection, and until fully in use, we could not determine effectiveness.

From inspecting the four units, we identified that each unit worked in isolation, and staff did not share ideas or outcomes from incidents as a means of learning and service improvement. For example, while speaking with one of the unit managers, we identified that they were planning to devise a shift handover form that could be used with agency staff. We told the unit manager that we had seen an example on another unit, that they could adapt to suit their needs. The management team were not identifying shortfalls on units, and encouraging sharing of information and ideas across units as a means of addressing them.

We reviewed team and staff meeting minutes. Issues were discussed, but action points, timescales and names were not attached for completion and accountability. We noted that staff had identified concerns with safe storage of risk items such as creams, and the need to ensure that staff were routinely filling out records such as repositioning, food and fluid charts. From our inspection findings, the registered manager and provider were not reviewing concerns raised during meetings to implement changes in practice.

Daily care records and other records were not all stored securely, instead being left in communal dining areas making the information accessible to other people living at the service and visitors. This impacted on people's right to expect that their personal information was held confidentially.

Staff told us they worked closely as a team, to offer high and consistent standards of care and treatment. Staff morale was variable, and staff told us this related to staffing pressures, and the impact on permanent staff of working with agency staff less familiar with the service. Staff gave inconsistent feedback about the quality of the management team.

Relatives told us they did not feel comfortable raising concerns with the management team, as this required them to speak in an open plan office. Relatives told us when they had attempted to raise concerns, other members of staff based in the office had intercepted and made comments affecting their confidence to raise further concerns.

Some staff identified the need for greater levels of support and oversight from the registered manager and provider.

We reviewed complaint investigations and noted that outcomes and action points from investigations were not consistently disseminated with staff as a means of improving standards of care. Some investigations lacked objectivity from the registered manager, and would have benefitted from greater oversight either from the provider or an external reviewing body.

We were not told of any staff under performance management at the time of the inspection. However, the registered manager told us they completed regular spot checks during the night. Recently as an outcome of a spot check, they had found five members of staff, including a registered nurse asleep on shift. The decision was taken for staff to be dismissed. The registered manager or provider had not notified CQC, the local authority safeguarding team or the Nursing and Midwifery Council of this incident. We could not be assured that the home followed performance management and HR processes.

Unit managers did not consistently demonstrate leadership in areas of practice such as implementation of the Mental Capacity Act 2005. This was reflected in the quality of care records, where capacity assessments were either not in place, or only in place for day to day decisions and choices rather than question specific decisions relating to care and medical treatment provided.

Due to low staffing levels, we identified that unit managers were providing hands on care to people, impacting on their ability to complete and keep up to date with managerial roles and responsibilities such as completion of care plans, risk assessments and quality checks of daily records.

Some unit managers and staff lacked insight into the risks associated with items such as prescribed creams, drink thickener, razors and toiletries being accessible to people living at the service. They had not ensured these items were locked away. Many of the people living at the service lacked insight into these risks and relied on staff to protect them. Whilst the registered manager and provider had not completed environmental risk assessments in relation to these risks across the service, the unit managers had not implemented anything autonomously on each unit.

We spoke with a nurse about creams being unlocked in a person's bedroom. Rather than going and locking the items away, or raising this issue with staff, the nurse told us that the person's relative had left the creams out. When asked if the relative had visited that day, we were told they had not been on the unit since the day before. Staff had therefore been in and out of that room and provided care, and not identified or addressed those risks. This also demonstrated poor leadership by the nurse who was in charge of the unit

We identified a communication issue between the registered manager and the unit managers. We escalated our concerns about risk items being accessible during the first day of the inspection. The management team provided assurances that these concerns had been disseminated to all unit managers and a plan put in place to mitigate the risks. On the second day of the inspection, we identified risk items remained accessible, particularly on Fern unit. This was when we identified they did not have lockable cabinets in place. The management team had not spoken with the unit manager to implement an interim arrangement. When we visited the home on the third day of the inspection, a level of improvement was evident, however, we still found prescribed items such as creams not locked away.

The management team had not implemented interim risk management plans while the kitchen doors on Lily and Fern units were not closing securely. The door on Lily unit had been reported to the maintenance team 10 days before the inspection visit but remained unresolved.

The above information meant the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overnight between the first and second days of the inspection, there was a power outage on one half of Lily unit affecting electrical items including profiling beds and pressure mattresses. The power remained off when we attended the shift handover meeting at 7am. This impacted on the running of the unit. We spoke with the management team, who advised that they did not intend to submit a notification to CQC regarding this incident. We noted that the home's business continuity plan did not include management of risks associated with power outage and failures, affecting equipment such as profiling beds and pressure mattresses. It is recommended that a contingency strategy is considered in this area.

Not reporting the power outage along with the safeguarding concerns relating to pressure care, dismissal of staff and unexplained scratches raised concerns that the registered manager and provider were not meeting their legal requirements to submit notifications to CQC. This was an area of concern identified at the last

inspection.

The above information meant the provider was in breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Staff demonstrated awareness of the service's whistleblowing process to enable them to report concerns or areas of unsafe practice. We were not told of any whistleblowing concerns under investigation at the time of the inspection.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The care provider was not always submitting notifications to CQC relating to incidents and safeguarding concerns. Registration Regulation 18 (1) (2) (b) (c) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care provider was not always providing person-centred care and support. The care provider was not encouraging people to have choice and control over their daily life. Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The care provider was not always providing dignified and respectful care and support. Regulation 10 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The care provider did not always work within the principles of the Mental Capacity Act (2005).

Regulation 11 (1) (2) (3) (4) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The care provider was not always reporting safeguarding concerns to statutory bodies and to CQC to keep people safe. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The care provider did not ensure that monitoring and recoding of risks relating to people's food and fluid intake were well managed. Regulation 14 (1) (2) (a) (I) (ii) (b) (4) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The care provider did not ensure there were sufficient staff on shift to meet the care and support needs of people living at the service. The care provider did not ensure staff had sufficient skills, performance monitoring and training to meet the requirements of their role. Regulation 18 (1) (2) (a) (b) (c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The care provider was not managing risks to ensure people and their care environment were kept safe. Regulation 12 (1) (2) (a) (b) (c) (d) (f) (g) (h)

The enforcement action we took:

Conditions placed on the provider's registration to remain imposed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The care provider did not have good governance procedures in place. The care provider did not always complete audits and quality checks. The care provider did not have good leadership in place. Regulation 17 (1) (2) (a) (b) (c) (e)

The enforcement action we took:

Conditions placed on the provider's registration to remain imposed.