RV Care Homes Limited

Charters Court Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 15 August 2018. It was unannounced.

Charters Court provided nursing, residential and residential dementia care. It is registered to accommodate up to 60 people. Charters Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

On the day of our inspection there were 47 people living at the home.

The home is a modern purpose-built building, which was on two floors. There were four self-contained houses each catering for up to 15 people in each. One of these was dedicated to people living with dementia and another for people with nursing needs. The other two houses were for people needing residential care, a number of whom live with some cognitive impairment. Each house has shared facilities such as a lounge and dining area, adapted facilities and individual en-suite bedrooms.

On the day of our inspection the registered manager was not present due to being away on holiday. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The Deputy Manager was present and supported us with the inspection. Following the inspection, we spoke with the senior manager responsible for the service.

This was the first inspection since the service was registered with a new provider in Sept 2017. The last inspection with the previous provider was in November 2015 when it was rated as "Good." At this inspection we had concerns about staffing and about the management of the service. This had an impact on the safe care and treatment of people living at the home. Improvements were required, and action was needed from the new provider to address the issues we found.

People's care and well-being was affected by a loss of permanent staffing over the past six months and an over reliance on agency staff who did not always know about people and their needs. There was a risk of insufficient staff deployed across the service, including that of qualified nursing care. Medicines were not always administered on time and in line with the home's own policy and best practice.

There were risks to people's safe care because of the lack of instructions for staff on managing people's risk and lack of knowledge by agency staff coming to work at the home. Where people had behavioural needs, the best approach for management and support was not well recorded for staff.

People's mental capacity to consent and make decisions about their care or medicines was not being assessed and recorded in line with the legal requirements of the Mental Capacity Act 2005 (MCA). Where

decisions were made on the person's behalf, in their best interests, this was not always well documented.

Not all staff were compliant with their mandatory training which may put people at risk. There had been delays for staff in getting access to online training in place and receiving one to one supervision from a manager.

Care plans, daily records and reviews did not always show how people were involved and include their preferences, views or personal information to ensure personalised care could be provided.

The assessment of people's hydration levels, where they were approaching the end of their life, needed to be improved.

The new provider and management of the service was not well thought of. Some staff, relatives and people were concerned about a deterioration in the service and they did not always feel they were being listened to.

Whilst staff were committed, they told us they were not happy. They did not feel involved, valued or supported. At the inspection, the deputy manager demonstrated good knowledge of people's needs and of the care delivered. They asked for support from their senior management but no one could attend.

There was a governance framework and quality assurance processes in place for monitoring care standards. However, it had not been implemented fully. Where improvements had been identified, the provider had not yet taken sufficient action.

People were protected from the spread of infection through good practice and cleanliness of staff. The home was furnished and decorated to a high standard, with a design that gave people a comfortable, homely and accessible environment. Building and equipment maintenance and health and safety checks were done.

People were safeguarded from abuse by staff who had an awareness of the policies and process for reporting concerns. Safeguarding issues had been reported to the local authority and notified to the CQC.

The storage of medicines was safe and people's wound care was well managed.

People's needs were assessed and recorded. Staff worked together and tried to support any agency care staff. Staff liaised with external services to meet people's specialist healthcare needs and maintain their health. People's nutritional needs were well met and they were provided with a choice of food.

People were looked after by kind and caring staff. Most staff involved people in their care and communicated in a respectful way, promoting choice and independence. We recommended to the provider that a good standard of communication should be made consistent with all staff and across the home.

People were given a choice of day to day activities and outings were arranged each week. People's wishes for the end of their life were being recorded in their care plan.

There was a complaints policy in place and on display. Statutory notifications were being sent to the CQC as required. The service was working with partners in health and social care to access learning and take part in forums.

During this inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We made one recommendation to the registered provider.
You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks people experienced were not always well assessed or managed.

Medicines were not always administered safely and on time.

Learning from accidents and incidents was not robust.

There were not enough staff to meet people's needs. The service relied on the use of agency staff, who did not always know about people and their needs.

Staff understood their responsibilities to safeguard people from harm. Staff were recruited safely.

People were protected from the spread of infection and the environment was clean.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not always working in line with legal requirements of the Mental Capacity Act 2005 (MCA) with regards to people's consent issues.

Supervision and training of staff needed to be improved.

People's needs had been assessed. People's nutritional and dietary needs were met.

People were supported to maintain their health and well-being.

The premises were adapted and well maintained to meet people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People said that agency staff had a less than caring attitude than permanent staff.

Some staff were task focused in their approach. We have made a recommendation about improving staff communication.

Staff acted to promote people's independence and protect their privacy.

People were supported to maintain relationships with their family and friends.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans, daily records and personal reviews did not always support or reflect personalised care and people's views.

People at end of life were at risk of not having their hydration needs assessed.

People had access to different activities and could go on outings.

A complaints policy was in place.

Is the service well-led?

Inadequate

The service was not always well led.

People and relatives said the service had deteriorated under the new provider and management.

People, relatives and staff did not always feel involved or that they were listened to.

A governance framework was in place but was not yet effective.

Quality assurance systems and an improvement plan had not been acted on.

The service accessed local partnerships to support learning.

Action was needed by the leadership to address the concerns we found.

Charters Court Nursing and Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 15 August 2018 and was unannounced.

The inspection was carried out by two inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service. This included the previous inspection report and notifications since the last inspection. Notifications are changes, events and incidents that the service must inform us about. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR as part of this inspection.

During the inspection we spoke with eight people and three relatives. We spent time observing interactions between people and the staff. We interviewed five of the care staff, the chef, the nurse on duty, an administrator and the deputy manager. The day after the inspection, we also spoke with provider's senior manager who was responsible for this service.

We looked at the care plans for five people, including their personal risk assessments and medicines charts. We checked that what was detailed in these plans matched the support and care that people received. We looked for mental capacity assessments and any applications made to deprive people of their liberty.

We checked whether mandatory policies and procedures were up to date and in place. We reviewed the recording of accident and incidents in the home, checked four staff recruitment files, and the evidence of staff training.

We looked at documentation that showed whether regular tests, monitoring of equipment and of the premises were being done. We reviewed any recent internal audits, improvement plans and responses to complaints and feedback, to understand how well the service was being governed and managed.

We later received some feedback from two professionals who have visited and worked with this home.

Requires Improvement

Is the service safe?

Our findings

People told us that although they felt safe living at Charters Court, they had concerns regarding the availability and the quality of staff supporting them. One person said, "I am safe with the regular staff, they are absolutely fantastic, but the agency staff don't know about you and you have to tell them what to do. No, I don't feel safe with the agency staff." Another told us, "They always seem to be short staffed. Last night there was only one male agency carer on the unit and he came and asked if he could get me to bed. It can be disconcerting to have lots of strange faces." Other people told us they did not feel safe being looked after by agency staff because they were not confident they knew their needs.

Risks to people's safety and well-being were not always thoroughly assessed and monitored. Care plans did not always provide risk assessments and guidance for staff. This meant that new or agency staff coming to work at the home may not have the information they needed. For example, a person who was nursed in bed was at risk of strangling themselves with their call bell cord. The guidance for staff to address this was not robust and there was no evidence of checks in place to keep this person safe. A staff member said they "Pin the call bell to the bottom of [person's] cardigan," as the person liked to know where call bell was, but we saw that the cord was still long enough to be a hazard. Another person had risks associated with a specific health condition that were documented but with no guidance for staff on how to manage this. We brought this to the attention of the deputy manager, who developed new risk assessments for these people and sent them to us the day after the inspection.

There was also a risk that staff may not know how to provide the most appropriate care to people who were verbally and physically aggressive with staff. There were two people where this was a risk with no behaviour plans to guide staff. One member of staff told us they would be informed in advance when they cared for them. We asked the deputy manager to put in place behavioural plans to assist and guide staff which they agreed to do.

Information was missing or incomplete in some people's care records. Two people had bed rails in place with no risk assessments to ensure they were being used safely. One person had a falls risk assessment that said, "Review monthly" but was last dated May 2018. One person had a skin care risk assessment. The actions stated that a foam mattress was in use but we observed that the person was cared for on an air mattress. This meant that staff did not have the most up to date information, including the type of mattress and any settings required. We brought these issues to the attention of the deputy manager.

Some medicine was not given at the prescribed time to one person. The nurse stated this was because the person was not awake or ready the time so they returned later to administer their medicine. However, there was no record made on the medication administration record (MAR) of the time the medicine was given. This meant that there was a risk of the medicines being given with a shorter time between dosages than was recommended. This was not in line with the homes' own policy and procedures for medicines. The nurse carrying out the medicines round did not wear a tabard to signify the round was in progress and should not be disturbed, in line with good practice guidance. Other staff members asked questions of the nurse during the medicines round, and the nurse had to stop the round to answer phone calls. This added to delay to

people receiving their medicines in a timely manner.

One person's MAR was not consistent with their care plan so that whilst some medicines had been stopped the MAR continued to show they were being given. This meant staff did not have the correct information to work with when administering medicines. Where another person required a pain patch, the record of administration was inconsistent. One patch applied had not been signed for, although the body map showed where it was applied. With another patch given the body map did not record the site of application. This meant that staff administering a new patch would not know where to place it on the person.

New paperwork had been brought into use across the home. Most people had a personal emergency and evacuation plan (PEEP) in place which detailed their medical condition and any physical constraints in case of an emergency evacuation. However, in one house a person's plan was missing and in another the old paperwork was in use and there were no PEEPs evident. There was a contingency plan in place, in case of a major incident that affected the ability of the service to provide care. However, although dated April 2018 this was under the old provider's format and had out of date provider contact information. The risks have not been fully assessed and the business continuity plan was not complete.

Accidents and incidents were being recorded consistently after they had occurred using the providers electronic system to log every incident. We could see this method was in use with events logged. In July, there had been five recorded accidents, all of which were falls. In June, there were twelve reported incidents including two medicines errors, and one safeguarding concern. The deputy manager told us, "The data is reviewed by the compliance team in the head office to ensure that the correct actions were taken." However, there was no apparent review by the registered manager to support any ongoing learning or to minimise the risk of them happening again.

These failures to assess the risks to people's safety, to mitigate known risks and to follow safe medicines practice were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were not enough staff to care for them. One person told us, "I sometimes feel rushed because the staff have so much to do and there's so few of them." Another told us, "They are so short staffed I often have to wait a long time for help getting up in the morning." Two relatives told us a nurse who had worked a night shift was then required to work during the following day as well due to staff shortage. The deputy manager said the provider sourced agency staff for them and on occasions, "Staff do not turn up." The deputy manager was a registered nurse and worked extra shifts to reduce the reliance on the agency or at short notice which had an impact on their management role.

There were not enough staff to meet people's needs. The provider was not using a dependency tool to determine staffing levels which meant that it was not clear what the staffing levels should be to meet people's needs. The service was separated into four 'houses' one of which was for those with nursing needs. In this house there was a nurse and three care staff, for the other three houses there was one senior care staff and two care staff. The nurse was administering medicines across all four houses and was expected to do this as well as other duties, including providing personal care with care staff, when needed.

Whilst we did not see any impact on the day of the inspection, staff told us they were rushed. One staff member said, "Some days you look at the rota and think 'how will we cope'?" In one of the houses staff told us said they were unable to take a break. One person who required staff supervision so they could smoke had to wait outside until staff returned from other duties. There had been a trip arranged for seven people but there were initially not enough staff to support this. The trip did go ahead but this left one member of

staff to support six people for the afternoon. Recent staff meeting minutes detailed night staff were being asked to get people ready early in the morning to reduce the burden on day staff.

There had been a number of staff who had left recently and the use of agency staff had increased significantly. This had affected the confidence people had about the care they received. One person told us, "One agency nurse didn't change my catheter because she didn't know how, and I ended up having to go to hospital". One relative said, "My concern is the loss of staff and that agency do not know my mum's needs." There was also only one permanent registered nurse and one bank nurse on the rota in the daytime, in some weeks, four days out of seven a different nurse was supplied by the agency putting continuity of care at risk.

Failure to provide and deploy sufficient staff to safely meet people's needs is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities). Regulations 2014.

Immediately following the inspection, the provider advised us they were recruiting for nursing and care staff. There was also access to an 'on call' team which provided 24-hour support by the service.

Some risks for people were managed appropriately and well. People who needed wound care had an assessment and review care plan in place with clear instructions on products to be used for cleansing and dressing the wound. Photographs and body maps were used to chart the progress of the wound's healing or deterioration. For example, one person with a leg ulcer, who was also diabetic, had a wound care evaluation plan, with a body map, that was reviewed regularly. They had an air mattress to support their skin integrity. A person who smoked and had sustained a skin burn was now wearing an apron as stated in their care plan and being supervised by staff. At the meal time, staff ensured people were sitting upright to take their medicines, or to have a drink and something to eat, to avoid any choking risks. They responded quickly to a person who did start to cough and choke.

The storage of the medicines was safe. Dates were written on liquid medicines to ensure that they had not been opened for longer than recommended. Medicines were stored in locked wall-hung cabinets or a trolley which could be bolted to the wall in the clinical room. Medicines requiring storage in a fridge were stored in the locked room with regular temperature checks. The trolley was always securely locked when removed from the room and when the nurse had to leave it for any time. There was a safe system in use for the administration of specialist drugs which was signed by two members of staff. Disposal of medicines was also recorded clearly, with the details documented as required by the home's policy. The home had a medicines policy in place which had been written with guidance from the Nursing and Midwifery Council (NMC).

People who had been prescribed 'as required' medicines (PRN) had protocols in place, which detailed the reason the medicine had been prescribed, the strength, maximum dose, frequency of administration, maximum dose within a 24-hour period, and whether the person could ask for the medicine independently. Pain charts were in use, to determine if a person who was unable to verbalise was in pain and required medication.

Safe recruitment practice was used prior to staff starting their employment. Staff recruitment files contained application forms, evidence of face to face interviews and written references from past employers. Evidence was also available to show that Disclosure and Barring System (DBS) checks had been completed. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. The nurses were registered with their professional body; the Nursing and Midwifery Council. Staff we spoke to also confirmed that they had undergone recruitment checks prior to starting work at the service.

People lived in an environment that was clean and were protected from the spread of infection.
Staff understood the need to use personal protective equipment (PPE), such as aprons and gloves, and to ensure they washed their hands before and after undertaking tasks which could increase the spread of infection. Each house had its own sluice room, which was accessible only by staff using a key pad. The rooms were clean and stocked with PPE as well as hand wash facilities, a bedpan washer, room to store laundry trolleys and clinical waste. Cleaners maintained a good standard of cleanliness throughout the home in all the communal areas including the bathrooms. We could also see that people's rooms were kept clean. A relative also commented, "The cleanliness side of the care is great."

People were safeguarded from abuse. Staff showed an awareness of the need to escalate any concerns. There was a policy in place with the process for referrals on display. There were also reminders to staff to be vigilant and to ensure they did not let strangers into any of the houses.
One staff member told us they would, "Report any abuse to the manager" and if they didn't feel that they were acting appropriately they would whistle blow to the local authority of the CQC. Another said they had received their yearly mandatory training under the old provider. Safeguarding issues had been reported to the local authority and notified to the CQC. The deputy manager had sought advice from the CQC about statutory notifications, and the local authority safeguarding team following an injury a person sustained after a fall and about a complaint about poor night time care. This had resulted in learning about when and what to report and outcomes had been documented.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who 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 capacity to make decisions, any made on their behalf must be done so in their best interests and in the least restrictive way possible. A person can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were not always respected as the principles and requirements of the Mental Capacity Act 2005 were not consistently followed. Assessments to determine people's capacity to make a particular decision were not always completed. Where a decision was made in a person's best interests, this was not always recorded. For example, we looked at records of three people who had bed rails. There were no mental capacity assessments or documented consent in place for their use. Care plans included a generic mental capacity assessment about the decision and restriction to live at the home, but we saw no assessments of mental capacity to determine if the person could make any other decisions independently. Information about a person's mental capacity and ability to give their consent was also confused. For one person the risk assessment for bed rails referred to a best interest's decision but we found no evidence of this or how it would have been arrived at. Instead we saw a signed consent from, even though there were indications the person lacked capacity to retain the information or understand the risks.

Two people were given their medicines in a covert manner (without their knowledge or consent). For one person, their care plan included that staff had discussed the need for this with the person's next of kin and their doctor, to ensure the decision made was in the person's best interests. However, there was no evidence of an accompanying mental capacity assessment to determine the reasons why this was needed. The other person did not have the required capacity assessment or other information to demonstrate that the decision to give them medicines covertly had been made in their best interests.

The evidence to support DoLS applications was not always in place. Two people, who were subject to a DoLS application did not have evidence of any best interest's decision making or a meeting. For one of these, the external DoLS assessor had subsequently found them to have full mental capacity to decide about their care and accommodation. There was a record of all the applications made for DoLS and this showed that seven applications had been made prior to any mental capacity assessment or the person being made. We raised these issues with the deputy manager at the time and they agreed to start the process of improving the documentation and to seek advice to meet this legal requirement.

We did observe that staff asked people for their consent and supported people with their decision making when giving care.

Failure to act in accordance with the Mental Capacity Act 2005 and code of practice was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

People and their relatives expressed concerns regarding the competency of agency staff. One person said, "There are an increasing number of them, from the agency, it worries me. One showered me with my shoes on!" Another said, "We have quite a few agency staff and they are not so good." Staff told us there were strategies in place to help agency care staff who may be new to the home. One staff member said, "Any new or agency care staff work alongside permanent staff, and will always get a handover." The provider had a contract with an employment agency, who both vetted and checked the qualifications of temporary staff, However, the feedback we received was consistent, that staff expertise had deteriorated in recent months and there was a lack of trust in the skills of the staff from the agency.

Staff had not completed all their mandatory training. For example, over half of the regular staff were not up to date with the manual handling training . There were also a high number of staff who now needed their yearly update on infection control, and on fire and emergency procedures. During the inspection we did not see any unsafe practice by staff, but the records showed the new provider was failing to ensure staff were appropriately supported to maintain their knowledge in these areas. Furthermore, the transition to a new online training system had resulted in delays for staff being able to update themselves on the skills and knowledge they required in their role. One staff member said, "We've had no updates or training with the new provider yet, we are all waiting for the new system." The deputy manager told us that they had raised these issues with the new provider, and some facilitated sessions were planned.

Supervision of staff had also become irregular during the first six months of this year, since the previous registered manager has left the service. The supervision records were inconsistent for this period and some staff had not had any one- to- one supervision. The provider policy is that staff receive supervision a minimum of four times a year and an annual appraisal. The new registered manager had set up a supervision schedule, from June 2018 and some staff had received supervision recently. They had discussed issues such as training, uniform, and the role of supervision going forward. We did not see any evidence of staff appraisals taking place.

Failure to provide and ensure appropriate support, training and supervision for all staff working at the home was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to have a balanced diet and their nutritional needs were being met. Where people were identified as being at risk of weight gain or loss, a monitoring record was in place. Action was taken if a person lost more than 10% of their body weight and a referral to the dietitian made. One person was referred to a dietitian and required enteral feeding via a percutaneous endoscopic gastrostomy (PEG) tube. This allowed nutritional food to be transferred directly to the person's stomach. There was specific care plan for maintenance of the PEG, and the amount and content to be given including medicines administered via the PEG. Staff we spoke with were knowledgeable about the person's nutritional care plan. There was information in the kitchen about each person's specific nutritional needs, which matched the information we had seen in people's care plans. Staff could also tell us about foods that some people had to avoid when on specific medicines.

People were given some choice about what to eat and drink. At lunch, the food served reflected the menu of that day and there was a vegetarian option. People were provided with a choice of drink, blackcurrant, orange squash or water. There was communication between the kitchen and care staff about people's menu choices for each meal. The chef said they could make a simple meal if a person did not want what was on the menu and would also cater for individual or cultural needs if they are made aware of them. One person often asked for something to eat at night time. The chef ensured that there are always sandwiches and snacks left in the fridge. One person told us, "They do bring biscuits and tea around morning and

afternoon and they make you a snack or sandwich outside of meal times if you want it." People were asked to choose from the menu the day before, where possible, and we saw staff asking people for their choices. However, some people living with dementia could not choose without seeing the meal visually, or they had forgotten what they had chosen. There was no pictorial format of the menus which might assist some people to choose their meal.

People's physical and medical needs were assessed and recorded. The care records contained an initial assessment of needs prior to admission to the home. The initial assessment included a detailed medical history and the person's current physical and emotional needs. Staff had access to good practice guidance on specific issues they might be dealing with, for example advice on helping people in extreme heat conditions as had been recently experienced.

People were supported by staff who worked together and with external services to provide care. A GP visited the home twice a week and people could see them by appointment or if the staff needed advice they could refer someone. People were referred to a speech and language therapist or to the dietitian, where required, and their advice and recommendations were incorporated into people's care plans. One healthcare professional told us, "Staff follow our advice and call us when they have concerns or someone needs a review."

People had access to specialist healthcare services and were supported to maintain their health. Professional visits and interactions were clearly recorded within the person's care plan, including screening programmes for diabetes, referrals to the dietitian, and nurse specialists such as the Parkinson's Disease specialist. Temporary care plans were used when a person's health care needs changed or required more support. For example, when a person developed a chest infection, staff referred them to their doctor, and ensured that the changes to their care such as new medication were recorded in their care plan.

People lived in an environment which was furnished and decorated to a high standard. Each individual house was well decorated and designed to be a comfortable and accessible home. The smaller, self-contained houses meant that people could experience a homelier environment and communal areas were easy to find. The corridors had handrails in place for those who needed them. People's rooms were individually decorated and each one had a specially adapted shower room and toilet. The call bells in toilet were at the correct length for people to use in an emergency. The building and equipment was well maintained and there was evidence that regular servicing and health and safety checks were in place and being kept up to date. Efforts had been made to display memorabilia, items of interest and old furniture in the corridors and lounges, which would be familiar to those who lived there and to support people living with dementia to navigate themselves to their room. However, further improvements could be made. For example, to ensure that all people living with dementia had a photograph or visual representation of themselves on their bedroom door to help them identify which was theirs.

Requires Improvement

Is the service caring?

Our findings

We observed caring and kind actions from staff. One person said. "They are stretched, but they always treat you with courtesy. I've never heard anyone cross or irritated, they never make a fuss." Another person told us, "The best thing about the home is the regular staff who look after you, they are the ones that do all the work and make the difference to your life."

However, people made a point of distinguishing between the care from permanent staff who they knew against that of agency staff. This meant the service could not always be described as caring. One person said, "I feel the agency staff just treat it as a job to be done. They don't want to chat to you or get to know you. You get the feeling they don't want to be bothered."

We also observed that there was less communication between staff and people in one house. Staff did not speak unkindly, but they were task focused. For example, at the lunch, one of the staff approached a person and told them to, "Lean forward so I can put this on you", without asking them. Some people were not offered a choice as staff said, "Here's your meal" and put the plate down. One person's view was, "Like anywhere some [staff] are better than others and take more time with you, when they have it. Some will have a little joke with you, others just do what needs to be done and move on."

The provider had recently introduced a weekly 'dignity in dining audit'. This was completed by staff to monitor the quality of the dining experience and ensure people were given choice in a way they understood. There was a box for feedback from people, though this had not been completed in the one we saw. The provider had also told us in their information return (PIR) that they had introduced, a 'Plate and show of the meal choices' for people living with dementia at lunchtime. However, we did not see this happening in all the houses where people with dementia lived.

We recommend the provider ensures a consistent standard of communication from all staff working in the home and that choice is offered in a way all people understand.

People felt able to express their views and were involved in the care. One person was clear, "They do take the time to ask how I want things done and if it's okay for them to help me. I do feel I have a choice about what happens to me." Another said, "The regular staff know us well but even so they always ask what you want done and how. In one house, we observed people were asked if they had finished their food before taking their plate away. We observed staff asked people if they needed any help and they were not rushed into answering. The person's response was respected. Where help was provided, this was done in a respectful way. One of the care staff said to a person, "You sit there as long as you want, my love." Another comforted a person who was confused. They crouched down to be at the same height as the person, and made sure there was eye contact, before touching them gently on the arm to reassure and explain what was happening.

People were supported emotionally. One person told us" I can't speak highly enough of the regular carers, they are so kind and willing to help you in any way they can. If I get upset or don't feel well they'll put an arm

round me and give me a hug."

We saw a member of staff assisting a person to the bathroom. They linked arms and were chatting and laughing together. People were relaxed and comfortable in the presence of staff and there was genuine affection shown.

People were encouraged to be independent by staff. Although people needed help with washing and dressing, people said that staff were patient and asked them what they wanted help with. One person said, "I like to be as independent as I can be, they know that and encourage it, after all it makes their job easier if I can do things for myself and don't have to wait for them. If I want help I can ask for it and they are more than willing but it's not pushed on you." Another person added, "I find them very kind and efficient, not over bearing, and they make the home as happy as they can. The attitude of the regular staff is very good".

People were given their privacy. We observed staff knocking on people's doors before entering, and any personal care given behind closed doors. One person celebrated their birthday and was afforded the space to see their family. The person took a phone call from a friend. The staff member gave the phone to them and left them to take the call in private. We noticed that family and friends were welcomed into the home by staff.

Staff we spoke to wanted to tell us how committed they were to the people they cared for at the home. One staff member said, "I like looking after these people, I like helping, we do the best we can." Another simply said, "I love it, because of the people." The deputy manager said, "People come first."

Requires Improvement

Is the service responsive?

Our findings

Care planning and records did not always support staff to provide personalised care. A person's medical and care needs were clearly documented but there was less information on the person's socialisation, communication, family and cultural needs. There was some evidence of families being involved in the original care planning, but we saw two reviews where no one was involved and the person's or relative's views were not included. Staff knew about people's conditions and how much help they needed but did not know much about their individual lives and history. There was a section for 'Important things about my life' but this was related to their day to day needs, not the whole person. For example, where a person wanted a newspaper to read, this was noted and we saw the newspaper was given to the person.

A 'Resident profile' on each person was available in each of the houses. This had information on the person's day to day care needs, and their daily records such as their repositioning chart, fluid chart and personal care record. The daily records of care provided were written in a task-orientated manner, with timed entries such as, '[person] washed and sat in chair', or '[person] ate well today'. The language was focused on tasks needed to be done without reference to the person's thoughts, preferences or aspirations. The views of the person and their choices were also limited.

The provider used the 'resident of the day' method. This is a way of making sure each person's care plan, their food and any housekeeping needs are delivered in a way that suits them. The provider had told us (in their PIR) that, "Person centred care is delivered to each person in the way they want to be cared for, respecting and valuing their past and present wishes and preferences." However, the most recent 'resident of the day' records did not show that a housekeeper or a manager had seen the person or whether the care plan had been reviewed and any changes made. The information on people's preferences was sparse. We asked the deputy manager who said that the person would have been seen that day but it hadn't been recorded on the sheet. It wasn't clear that the method was used effectively and took the person's wishes into account.

Where people were coming to the end of their lives fluid charts were in use. However, the hydration levels of the two people who were at end stage care was not fully assessed to support their well-being, comfort and quality of life. The daily records for each person had included a target to maintain therapeutic level of fluids. One person's fluid target during that week had not been met with no evidence of any action taken. The other person's chart showed that the fluid records had not been totalled for three out of five days. One staff member said, "It's important to total the fluids to make sure [person] has reached or exceeded their target." However, when we pointed out this was not being done by all staff there was no explanation. The person had recently deteriorated, and no advice from hospice or GP had been sought yet.

The failure of the provider to involve people in their care planning, the lack of information about people's preferences and behaviour and the failure to assess hydration needs to support a person's quality of life was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's wishes for the end of their life were being recorded. One person had an advance care plan in place

which included the person's wishes regarding the level of care intervention they wished to receive towards the end of their life and where they wanted to be cared for. It also recorded how their spiritual needs should be met. There was information within the care plan which considered national guidance such as the Gold Standard Framework for care at the end of a person's life. There was something in each of the care plans we looked at about the person's end of life care wishes, even if quite basic information. One person's plan stated, "Wants to be comfortable and pain free. No particular religious, cultural or spiritual needs." Another said that they had asked for a "Visit and prayer from their pastor." The care home could access support from the local hospice and their GP to consult on advance care planning or anticipatory medicines.

There was a weekly programme of activities which people could choose to participate in. There were games and books available throughout home too. The service employed an activities co-ordinator and a driver. Twice a week there was an outing to the local community and a high tea for about eight people. Other activities were chair exercises, arts and crafts, song therapy, aroma massage and knitting club. People could choose what they liked to do or whether to opt out. We heard from people who said they would rather stay in their room. One person said, "The activities, such as they are, do not interest me but I have a lot of friends who come in to see me regularly so that's where I get my social contact." Another person said, "Another said "I am independent, I get about with my walker. I don't join in anything by way of internal activities, although I do go out in the bus sometimes for afternoon tea."

At the inspection, we did not find or talk to anyone who had any religious, cultural preferences, or who had needs that may arise due to their sexuality. The deputy manager said that they would accommodate any religious belief and support all people. One person had been provided with a white board in their room which staff used to communicate with them. This person had been struggling to understand and hear what staff said to them.

The complaints policy was clearly displayed within the home. One person told us "I was given information about how to complain when I came in although I haven't had to." Complaints and compliments were being logged. At the inspection, a relative told us about complaints they had made. These were about the lack of care, dignity and support given by staff. We raised the matter with the deputy manager who said they were addressing their concerns. Following the inspection, we requested further information regarding how the complaint was resolved. Although there was a delay in the formal response, due to absence of a registered manager, action had now been taken. The relative also said, "Things have stepped up a bit since." The person has now moved to a different home.

Inadequate

Is the service well-led?

Our findings

People and relatives told us that they had seen a change for the worse in the culture and staff morale at the home. We heard that some staff had left following the transfer to the new provider last year, but others had left more recently. A relative said "The new manager doesn't seem able to keep staff. Other people also told us they had little confidence in the provider and the leadership. For example, a person said, "The staff on the floor are very good but I'm not sure how much support they get from the management. Not enough I would say."

The stated vision of the care provider was "To create the kindest care homes in the United Kingdom. Our principles will help us to deliver this; Accountability, Involvement, Partnership" Although the transfer to the new provider had happened in September 2017, their philosophy and organisational aims were not integrated into the way the home was run.

People and relatives did not feel listened to by the management. People came to find us so that they could voice their concerns. One person told us, "We don't see the manager around the place, like the other one used to be. Another also said, "I wouldn't know the manager if I fell over them. They send out feedback forms but I don't bother filling it in. It won't change anything." A relative who spoke with us, said they had raised a concern with the registered manager but had not felt "Listened to." A person also said they had not been told what had happened as a result of their feedback, saying, "They wouldn't tell you if you asked." We asked about any regular meetings with people and their relatives. There had not been any since December 2017, since the previous registered manager had left.

Staff did not feel involved, valued or supported to make improvements. One staff member said, "I don't know who any of the senior managers are, as they have never been to the service to introduce themselves. With [name of old provider] the managers did this all the time and we felt we had great support." A staff meeting had been held in June. Some staff had raised concerns about the ability of agency staff to meet people's needs, they were told they must put the complaint in writing and be exact about the reason. One staff member said they felt that "The management is not approachable or supportive, and not listening." The team leaders had met with the registered manager to resolve this. But no changes had been made yet. There was a sign on the office door saying that staff could only speak to the registered manager at specific times of the day.

The new provider's care planning methods and systems were not fully embedded and we saw how this impacted on staff and their ability to give personalised care. The Provider Information Return (May 2018) had stated the deputy manager would be "Supernumerary post to concentrate on supporting & coaching the team with the integration of new systems." However, the deputy manager was very busy covering nursing shifts much of the week and this impacted on their ability to provide the backup role and make further progress on getting the care plans and paperwork up to date. The deputy manager said, "I am anxious about the situation because the staff are not settled."

On the day of our inspection, the deputy manager demonstrated good knowledge of people's needs and of

the care delivered. They asked for support from the provider, but none was forthcoming as senior managers were in meetings all day.

We contacted the provider's managing director for the service, following the inspection, and told them what we had found about the lack of confidence in the leadership and people's negative feedback about the staffing situation. They gave us reassurances that the staff and deputy manager would be supported by a new experienced area director and a visit was in place for the following day. They also acknowledged they had work to do to ensure the service and staff could evidence and deliver the quality they expected in their care homes.

The provider had a robust system and quality assurance process to monitor the quality of the service provided and corresponding records. A plan was in place detailing the weekly, monthly and quarterly audits that were required. For example, as well as a daily sample stock count of medicines given in each house there was a monthly audit of medicines and records. Twelve care plans were expected to be audited each month. Infection control, catering and falls were expected to be reviewed across the home on a quarterly basis. However, the provider's governance framework was not in full use with the service and there was little evidence of outcomes from the audits.

In June 2018, the provider commissioned an independent internal inspection. This highlighted the areas for improvement, including, "Considerable work" to complete and embed the quality standards of the provider. Some of the improvements they identified were ones we saw were needed, for example staff supervision and appraisals, accurate care planning and daily records, consistency and clarity with the use of the MCA, and some improvements in medicines management. Except for the staff supervisions, there was no evidence that the registered manager or provider had begun to implement the action plan to address issues.

There were other indicators that the provider checks were not being effective. For example, a bed rail usage sheet indicated that people using bed rails had a risk assessment in place, but we had found some that were missing. The 'resident of the day' a few days before our inspection was with a person where we noted risks that were not being addressed, but this had not been picked up on the review. The internal medicines audits did not pick up on the gaps in records that we saw.

The deputy manager told us that the service was still transferring over to the provider's care planning, quality assurance and data system in full. We have highlighted the impact this had on people's safe and personalised care in other parts of the report.

The failure to effectively monitor and improve the quality and safety of the service, to seek and act on feedback, maintain accurate care records and to embed a positive culture was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to notify the Care Quality Commission (CQC) of important events. Statutory notifications were being sent correctly to the CQC, including safeguarding concerns or incidents. We saw that the last CQC inspection report and rating was on display in the reception area as is required of providers.

The care home has created some links with the local community for the benefit of people living there. Based on what people said they wanted, a monthly church service is held and local school children visit at Christmas and other occasions in the year. We were told that the mayor visited the home and spoke with people in April 2018. The service has a professional link with the integrated response team in the local

community NHS trust. This team provides support and training for care homes. The deputy manager said that they hoped some staff could benefit from training coming up soon about the needs of people living with dementia.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Provider failed to involve people in their care planning, the lack of recorded information about people's preferences and behaviour did not support staff to provide personalised care. The hydration levels of the two people who were at end stage care was not fully assessed to support their well-being, comfort and quality of life.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's legal rights were not always respected as the principles and requirements of the Mental Capacity Act 2005 were not consistently followed. The evidence to support DoLS applications was not always in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to assess the risks to people's safety and mitigate known risks. Medicines administered late and not in line with own policy. No overall review of accidents and incidents in the service. PEEPS missing for some people and contingency plan not up to date.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The new provider was not effectively monitoring and improving the quality and safety of the service. They were not routinely seeking and acting on feedback from relevant people (residents and relatives). They had not embedded a positive culture or their own values.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Provider failed to provide and deploy sufficient staff to safely meet people's needs. Staff had not received mandatory training (manual handling, infection control and fire safety). Some staff were not being supervised in line with provider's own policy.