Pinerace Limited

Collamere Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced focused inspection of Collamere nursing home on 10 October 2016. We undertook this visit as we had received concerns in respect of a person's care at the service. Following this inspection visit we received further concerns in respect of the care and welfare of people using the service. We therefore undertook a further inspection visit to the service on the 4 November 2016 to widen our inspection to become Comprehensive. We also checked what action the provider had taken in relation to concerns raised at our last inspection in August 2106. At that time we found breaches of the legal requirements related to: medicines management, diet and nutrition, staffing levels, a lack of training and supervision for staff, not ensuring that care plans were in place or up to date, and ineffective auditing systems. We told the provider to take action to meet the legal requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Collamere nursing Home on our website at www.cqc.org.uk. The provider for this location is registered under the legal entity of Pinerace Limited. Pinerace Limited is part of the Morleigh group of nursing and residential care homes.

Collamere is a care home which provides nursing care and support for up to 46 predominantly older people. On both days we visited there were 27 people living at the service. Some of these people were living with dementia.

The service is required to have a registered manager in post. At the time of our inspection visits there was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager had been working in the service since April 2016. However, an application for the post of registered manager had not been submitted to the commission.

The provider has overall responsibility for the quality of management of the service and the delivery of care to people using the service. The provider has repeatedly not achieved this at Collamere Nursing Home and whilst it had a rating of Good on the first rated inspection in April 2015, it still had a legal breach in the area of management. Since October 2015 the Care Quality Commission has carried out a further four inspections (including this one) of the service and all have been rated as Requires Improvement. At each inspection there have been breaches of the regulations. The service has not met the requirements of enforcement action which they are required to do by law.

At the previous inspection in August 2016 we found that the temperature of the medicine fridge was not recorded as they did not have a thermometer. During this inspection, we found that medicines that required cold storage were kept in a medicines refrigerator in the nurses' office but a record of the fridges temperature was still not kept. Not checking the fridge temperature daily means that any fault with the

fridge would not be identified in a timely manner and medicines might be stored at a temperature that makes them unsafe or ineffective.

We also looked at how medicines were managed and administered. Records showed people were administered their medicines correctly. However, there were some improvements needed in the recording of medicines administration. For example, handwritten entries on the medicines records had not been signed by two people to help ensure the risk of errors was reduced and body maps were not used consistently when creams and pain relieving patches were applied. These issues had been identified at the August 2016 inspection and no progress to address them was evident.

Records were not up to date at the August 2016 inspection and we found continued evidence of this at this inspection. For example staff told us how they needed to approach a person in a particular way or the person may bite or scratch them. This was not reflected in their care plan. There was no risk assessment to help protect staff from injury. We found staff did not have the information, guidance or direction about when to provide certain elements of care to a person or what action to take if a person's health needs changed.

Records were not always completed by care staff when care and support had been carried out. For example, weight charts and food and fluid charts were not being recorded consistently. This did not allow staff to monitor people's health in a consistent manner and enable them to identify if any changes to their care were needed. This meant that appropriate care was not always carried out by staff.

At our previous and current inspection visits we found systems were not being operated effectively to assess and monitor the quality of the service provided. This meant the provider and manager were unable to identify or address any areas of concern. For example, at the August 2016 inspection we found that pressure mattresses were not at the correct setting for people's weight. The manager said they completed their own audit and confirmed that some settings were incorrectly set. However, they had not kept records of when they checked the pressure mattresses, when this was needed to be repeated or what action they had taken to help ensure they were correctly set in future. On this visit we again found that pressure mattresses were not at the correct settings. This meant that people were not protected from the risks associated with pressure damage to their skin.

We received concerns from a health professional regarding a lack of communication with the service. The impact of this was difficulties in the working relationships between the health professional and the service which could impact on the care people received at the service.

We found staff were supported by a system of induction, supervision and training, although this was not always recorded by the management team. The Care Certificate was not being used by the service to support the induction of care staff new to the role. This meant there was no evidence that they had completed the induction and had been deemed to be competent to carry out their role. Staff told us they had attended supervision and we noted that some training courses were being provided. Appraisals were now taking place. However, we concluded that there was insufficient evidence that induction had been improved or that all relevant training was being provided.

The service calculated staffing levels using their own assessment tool and we saw these numbers of staff were usually working at the home. Staff felt that staffing levels had 'improved' since the previous inspection and that they had more time to be with people. However, we were told by staff, and observed, that when people became anxious, staff did not have the time to be able to stay with the person until their anxiety levels had lessened. For example we observed a person not being provided with staff support at a meal time which meant that the person could not access their meal. We concluded that sufficient staff were employed

at the service to care for people's physical care needs. However peoples' emotional or psychological needs were not adequately met.

We found that people did not receive care and treatment that was responsive to their individual needs. For example when people called out for assistance continually staff were not able to spend the time needed until the person's anxiety had reduced. We found that the care provided to people was often task orientated rather than in response to each person's individual needs.

Staff reported continued concerns about the laundry service at Collamere. Comments included, "It's awful. We come in early to get the laundry done otherwise we would not have enough clean bedding". We took a sample of linen and towels which were worn, frayed and discoloured due to extensive laundering and a torn bed sheet to show the management team. Their response was to place blame on staff for drying pillows in the tumble drier and for staff taking new towels for their own use. The management team told us on the 4 November 2016 that they had ordered some bed linen. However, it is a concern that we needed to raise this as an issue in the August inspection and also on the 10 October 2016 before any action was taken.

At this inspection we found that recruitment processes were not followed consistently. For example, a member of staff who had been working unsupervised at the service, had not had their full Disclosure and Barring System (DBS) check before commencing work. The failure to complete necessary checks before allowing staff to provide care exposed people to unnecessary risk.

We identified there were difficulties in communication within the management team. For example following the August 2016 inspection, the head of operations had come to the service and commenced their own care plan audit. The manager had also introduced their own care plan auditing system which they had shared with nursing staff about how they wanted it to be completed. This demonstrated that there was no agreement between the head of operations and the manager as to how they would respond to an issue. This created confusion.

The manager had designed a new handover recording sheet to improve communication between staff. This sheet was used at shift handover, so that any changes to the person's care or any actions needed to be taken were recorded. This was to reduce the error of miscommunication between staff. However, we found that staff were not completing the handover sheet as instructed, which could lead to information not being shared effectively.

People's personal confidential information was not always stored securely. This meant that people could have access to confidential information.
We noted that the most recent inspection report was not accessible for people in the service and their families. Also the provider had not submitted an action plan about how they would address the shortfalls of their service. It was of concern that the management team had not openly shared with us how they intended to address the failings of their service.

We noted that there had been some improvements to the service. For example, the service had addressed the concerns regarding the quality and quantity of food provided for people. We received positive comments from people and their relatives about how the food had improved and that they now had choices of meals but would like their meals to be served hotter. The provider assured us they would make available a hot plate so that food was served hot. This had still not been put in place. This meant that the assurances made by the provider had not been carried out.

People, relatives and staff were positive about the appointment of the new manager. Staff commented,

"Things have improved although there is still a way to go." The manager received supervision with the head of operations and regular meetings took place with the managers of the other services in the Morleigh group.

An activity coordinator had also been appointed to the service which had been welcomed by people, relatives and staff. People were supported to maintain relationships with family.

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.

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.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

We are taking further action in relation to this provider and will report on this when it is completed.

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. Medicines were not always managed safely.

Staff recruitment checks were not always completed before they worked unsupervised.

There were not enough staff to meet people's needs if a person became anxious or needed more staff support.

Is the service effective?

Requires Improvement

The service was not entirely effective. Staff did not receive appropriate induction and training so they had the up to date skills and knowledge to provide effective care.

Staff supervision had commenced however, there was no documentary evidence to support this.

A balanced diet appropriate to people's dietary needs was available. However staff did not always support people with their dietary needs.

Is the service caring?

Requires Improvement

The service was not entirely caring. Staff were kind and compassionate when they spoke with people. However, some staff did not know how to manage people's anxiety appropriately.

People's privacy and dignity was not always respected.

People were supported to maintain relationships with family

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not receive care and treatment that was responsive to their individual needs. The care provided to people was often task orientated rather than in response to each person's individual needs.

People had access to a complaints procedure to raise issues of concern with the service and external organisations.

There were some meaningful activities provided to meet people's social and emotional needs.

Is the service well-led?

Inadequate

The service was not well-led. The manager had not made an application to be Registered for the service.

We found a number of concerns during our inspection which had not been identified by the provider or manager. This showed a lack of robust quality assurance systems.

Records relating to the management and running of the service and people's care were not consistently maintained

Collamere Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The first inspection visit took place on 10 October 2016. This inspection visit was carried out by two adult social care inspectors, a pharmacy inspector, and an expert by experience. The expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in older people's care. We received additional concerns following the inspection and undertook a further inspection visit to the service on the 4 November 2016, carried out by two adult social care inspectors.

Before the inspection, we reviewed the information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with seven people who lived at the service. Not everyone we met who was living at Collamere was able to give us their verbal views of the care and support they received due to their health needs. We also spoke to four relatives to share their views on the service. We looked around the premises and observed care practices.

We looked at care documentation for seven people living at Collamere, medicines records for 31 people (included some people who were no longer at the service), three staff files, training records and other records relating to the management of the service. We spoke with the deputy manager, manager, head of operations and the registered provider during the inspection. We spoke with nine staff during the inspection visits and one staff member following our visit.

Inadequate

Is the service safe?

Our findings

At the last inspection in August 2016 we found breaches in the regulations in the following areas, medicines were not managed safely and we had concerns around the safety of the premises. We also had concerns that staffing levels did not meet people's individual needs.

At the August inspection, we found that the temperature of the medicines fridge was not being recorded as they did not have a thermometer. During this inspection, we found that medicines that required cold storage were kept in a medicines refrigerator in the nurses' office. The fridge was not locked, but staff told us that the office was locked when empty and we observed this to be the case on the first day of our inspection, but unlocked on our second visit. This meant that medicines stored in the fridge were not stored securely at all times.

Staff told us that the thermometer used to measure fridge temperatures was broken and had been for some time. Records showed that the fridge temperature was last taken during the week beginning 29 August 2016. The temperature of the medicines fridge had not been recorded since then. The manager told us that they had asked for a new thermometer to be delivered. Not checking the fridge temperature means that medicines might be stored at a temperature that makes them unsafe or ineffective.

People told us that they received their medication on time. One person told us "I know what pills I should be taking, once an agency worker at the weekend got it wrong. I told him and on double checking he corrected them." We noted that the medicine records did not have photographs of residents placed on them. This would help staff to ensure that they were administering medicines to the correct person and reduce the potential for medicine errors.

Medicines were available, in date and suitable for use. Staff followed protocols for the administration of 'as required' medicines for some people, but not all. The protocols informed staff when and how to administer the medicine safely. Some people had 'as required' medicines but protocols were not in place. For example, one person was prescribed a strong painkiller to be taken regularly every twelve hours and at a lower dose in between if needed. There was no protocol in place to guide staff about when to give the painkiller or the maximum daily dose. We saw one person had a protocol for a painkiller to be given as required, but no tablets in stock and the medicine was not on the person's medicine administration record (MAR). This meant that the person did not have access to their painkillers if they needed them.

It was not clear on the MARs whether people's allergies or sensitivities to medicines were recorded. On some MARs the space for recording allergies was blank which meant that nurses may not be aware of a person's allergies at the point of administration. Care staff completed the majority of administration records when they applied simple creams and ointments. These records included information for care staff about where and how much cream to apply. Although there was a form available to nurses to record the site of application of a medicines patch, we saw that this was not always completed. This means that staff could not easily identify if the patch was still in place and rotate the site of application when a new patch was applied. A list of medicines that could be given to people for simple conditions were available, but had not

been updated since June 2012 and was not authorised by a GP. Nurses recorded medicines given to people from this list on their MARs.

We observed staff administer medicines on time and completed the MARs to show what medicines people had received. Staff gave one person their tablets from the medicines trolley, to take herself. The nurse signed the MAR to indicate that medicines had been administered. The nurse told us that the person had the capacity and understanding to take their own tablets, but this had not been risk assessed.

At the August inspection we found fire doors were not alarmed and therefore people who may be at risk could leave the building without staff being aware. On the first day of this inspection, one of the members of the inspection team was able to walk through two security coded doors and entered the service without staff being aware. When we asked how this was possible, staff responded that a person using the service was waiting for them outside. This meant staff were not aware of who was in the building at all times and it was not secure.

This is a repeated breach of regulation 12 of the Health and Social Care Act 20088 (Regulated Activities) Regulations 2014.

Staff were aware of the whistleblowing and safeguarding policies and procedures. However, the manager confirmed there had been no training updates since the previous inspection in August 2016 and therefore the findings from that inspection had not changed. Staff had not received recent training updates on safeguarding adults and were not aware that the local authority were the lead organisation for investigating safeguarding concerns in the County.

When we arrived on the first day of this inspection, we observed the fire door alarms were not working. During the inspection, a contractor came and repaired the alarms on the fire doors. During the visit the fire alarm system was tested and the system was working correctly. Fire safety drills had been regularly completed and all firefighting equipment had been regularly serviced. However, the manager told us training had not been updated since the previous inspection in August 2016 and therefore it could not be evidenced that all staff had received annual fire training. This meant that action had not been taken to address the concerns raised at our last inspection

At the August inspection we identified a breach in regulation in that staffing levels did not meet people's individual needs. We reviewed this at both inspection visits. People living at Collamere had mixed views about whether there were sufficient staff on duty. Comments included, "I check the staff levels every morning, if they tell me that there's a staffing shortage I try not to ring my bell so often. They are short of staff at night."

Care and nursing staff told us they felt that if the number of staff on the duty roster attended their shift, there were sufficient staffing levels on duty. However during our inspection visits some people, who were anxious, called out for assistance. Staff responded but did not have time to remain with the person until they settled. Staff told us, "We have people here who have very complex dementia care needs and we don't have the time to do it all. (A person's name) should have one to one staff as they are so distressed when left alone, call out and upset all the other people nearby." This is discussed in further detail in the caring section of this report. Staff told us there was insufficient laundry staff to ensure that laundered items were available for people to use in the service at all times. The impact of this is discussed further in the well led section of the report.

There were twenty seven people using the service at the time of inspection. The staffing levels were; seven carers, one qualified nurse, a cook, kitchen porter, domestic and laundry personnel were on shift during the

daytime. In addition a deputy manager and manager were available. On our second visit in November 2016 the manager told us that on some days the level of care support workers had increased to nine. However this level of staffing was not consistently delivered.

The service used a dependency tool to calculate the number of care hours needed during the day/night. When a person's needs changed, for example due to falls, we were told the care needs would be amended. From the evidence supplied at the time of this inspection, we concluded that sufficient staff were employed at the service to care for people s physical care needs. However peoples' emotional or psychological needs were not adequately met.

The staff roster showed that bank staff were employed on most days. However, they were not named on any of the rosters. The manager said, "I am not told the name of who is covering the shifts. (Registered provider name) arranges it. There is no way of knowing who the staff members are." The registered provider confirmed they arranged all the requests for bank staff to cover the entire company's care services and this was organised on a daily basis. The registered provider acknowledged they did not relay the names of bank workers to the service. We discussed the need for a record to be made of who worked on each shift so that there was accountability in how staffing was covered on a daily basis. For example, we noted that for the night time rosters they did not show if anybody had covered shifts when sickness was reported. By recording who had covered the shift this would evidence that sufficient staffing were allocated, to ensure the service provided the correct staffing levels at all times.

Therefore, we concluded that the concern around staffing levels contributed to the repeated breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a recruitment process which was managed at the headquarters of the provider. We asked to review the files of three recently employed staff. However only one record was available as the others were at the services headquarters. We found the relevant recruitment checks had been completed, for example Disclosure and Barring System (DBS) checks and the provision of two references. However, the record of the person's interview, their employment history, or a photo of the person, were not on file. On the second day of our inspection, we saw a staff member hand in a copy of their DBS which they had received that morning. However, they had worked at the service supporting people with their care needs alone and had not had a full DBS check before commencement of their employment.

DBS checks were completed by staff based at the provider's head office. On the 2 November 2016 we visited the provider's head office to gather information about staff start dates and the dates when DBS checks had been requested. We found that one staff member recruited in June 2016 had begun work 14 days before their DBS check had been requested. The failure to complete necessary checks before allowing staff to provide care exposed vulnerable people to unnecessary risk.
This is a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed moving and handling equipment such as handling belts was not always used appropriately. Handling belts should be used to help a person who can stand and feel secure during a transfer as care staff use the belt to keep them supported. We saw staff place a handling belt around a person's waist then take the person's weight by lifting them under the arms and gripping their arms. This is unsafe practice and could injure a person.

Therefore we concluded that this contributed to the repeated breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We received information of concern before our second inspection visit regarding staff moving people using the bottom sheet from their bed. We observed people in their beds and asked staff about their practice. We did not find any evidence that people were moved using their bed sheets. Staff told us that slide sheets were available in all rooms.

On the first day of our inspection visit we found the environment to be clean and free from offensive odours. However, on the second day of this inspection we noted some strong odours of urine in some parts of the service. Therefore the cleanliness of the building was not adequately maintained at all times.

Therefore we concluded that this contributed to the repeated breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Care plans contained risk assessments for a range of circumstances including moving and handling, supporting people when they became anxious or distressed and the likelihood of falls. Where a risk had been clearly identified there was some guidance for staff on how to support people appropriately, in order to minimise risk and keep people safe whilst maintaining as much independence as possible. For example, how many staff should support a person to move them safely.
People and their families told us they felt safe at Collamere. Comments included, "I feel safe here and looked after."

We saw on both days of the inspection that hand washing facilities were available throughout the building. Personal protective equipment (PPE) such as aprons and gloves were available for staff and were being used appropriately. All cleaning materials were stored securely when not in use.

Requires Improvement

Is the service effective?

Our findings

At the August inspection we found staff had not received regular training or support to provide them with the knowledge and skills to carry out their roles safely. Supervision sessions with the manager had not occurred regularly. This meant staff did not receive effective support and any on-going training needs or personal development requests may not have been acted upon.

At this inspection staff told us they felt supported and had conversations with the manager. This included supervision sessions and appraisals. Three records showed the staff member's current development and practice was discussed. However, two files stated that issues had been identified but there was no evidence about how the issue would be addressed. For example in one, 'Opening creams and reminded to sign and date' but there was no evidence of how this new staff member had been informed about this practice or if any training in this area had been carried out.

We noted that an appraisal record had been introduced looking at the overall competence and development opportunities for the staff member. However, there were no records available for nurses as the group's clinical lead, who was on leave, carried out these supervisions. As these records were not shared with the manager they were unaware of individual nursing staff training and development needs or if there were any issues to be addressed.

The manager told us that there had been no changes made to the training matrix (central record) since our August visit. From talking with staff and from posters on display of upcoming training we found evidence of some on-going training taking place. For example, Infection control and defibrillator training (emergency resuscitation). The manager was aware that the records of which staff had attended training needed to be recorded, as well as a list of when refresher training was due. The training matrix was not made available to the inspectors to confirm the status of staff training despite being requested during both inspection visits. On the second inspection visit the manager told us that the training matrix remained out of date and was held by another manager in the service. The deputy manager had written to all staff to ask staff them to list what mandatory training they needed to complete. This meant that the manager was unaware of what training they needed to plan to ensure that staff skills and knowledge were up to date.

At the August inspection we identified a breach in regulation as staff had not undertaken an appropriate level of induction when they commenced employment at the service. The induction did not incorporate the Care Certificate which replaced the Common Induction Standards in April 2015. It is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector. At this inspection we were only able to look at one file of a recently recruited staff member as two others were at headquarters. We were unable to find any documentary evidence that the person had participated in any induction. The deputy manager stated that the staff member had looked at some polices but was unable to evidence this. From our discussion with the registered provider, manager and deputy manager it was confirmed that new staff were not undertaking the Care Certificate or any formal induction process. The deputy manager told us some staff wanted to undertake other health qualifications at college but evidence of this was not seen. This meant there was no

evidence that they had completed an induction even though they had been deemed to be competent to carry out their care role without any formal assessment.

We concluded that induction, supervision, and training were not being provided adequately. Therefore this is a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the August inspection, we identified concerns in the management of people's diet and nutrition.
The only remaining issues in respect of food were that the catering staff did not have equipment to ensure the food remained hot before serving. The registered provider agreed that a hot plate would be made available for the service. However, on our second visit to the service it still had not been provided. This meant the assurances made by the provider had not been actioned.

Therefore we concluded that this contributed to the repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager told us the cook from another of their care home services came to Collamere nursing home following our inspection visit. This cook reviewed the Collamere food systems and from this it was identified that the service needed to follow the planned menu rota as staff had been deviating from it. It was felt that this had led to issues of insufficient foods being available. New systems were put in place so that food was now ordered in sufficient amounts correctly through headquarters. The visiting cook reviewed the cooking processes at Collamere and had fed back learning points. In addition, the cook from Collamere had been to visit the other cooks kitchen so that they had a greater understanding of what was expected of them.

Through discussions with people at the service they all commented that the quality and quantity of food had improved. Comments included, "It's nice", "I'm happy with the food. I've sent it back before as the portion was too big, it came back smaller, I do enjoy the food" and "I don't always like what they offer so I choose something that I would like to eat. I have had scrambled egg on toast instead. They will get me something that I choose." People confirmed and we observed that they were offered drinks throughout the day. Relatives were also complimentary about the food and supply of drinks to their family members.

Staff were positive about the changes and commented, "Things have got better. The ordering is easier now," "We have a set day to order things. We are getting what we need. Sometimes we need different things over the two week period but it's not that often," "The pureed meals look better now they are set out separately" and "There is a choice everyday now and we go and ask residents what they would like the day before. It's planned a lot better."

On our first visit we observed a lunchtime meal. This helped us record how people spent their time, the type of support they received and whether they had positive experiences. People were able to choose where they wanted to eat their meals, and ate in the dining area or in their bedroom. Lunch was leisurely and people enjoyed their food. We saw that people had a choice of main meals and the portion size varied according to the people's wishes.

Some people needed assistance from staff with eating. Staff provided sensitive prompting and encouragement to people when needed to ensure they ate their meal. Staff checked with people that the food choices were to their liking and offered people regular drinks.

We observed some staff respond to people's needs in a sensitive and caring manner, For example one person did not want to eat their meal. Staff regularly approached the person to see if they needed support.

The person declined but was encouraged to eat their meal with gentle coaxing. The person was asked if they wanted an alternative meal but this was declined. We also saw one person who became distressed and verbally agitated during the main meal. Staff members responded sensitively and with the assistance of another member of staff supported the person back to their room as this was causing distress to others at the table close by.

In contrast on our second visit we observed a person who did not receive the appropriate support or encouragement with their meal. We needed to intervene to ensure the person had access to their meal. This is detailed in the caring section of this report. This demonstrated the inconsistencies of the approach from staff in how they supported people with their meals.

The premises were mostly in good order. Some bedrooms had been refurbished. A large lounge had been redecorated. Bathrooms and toilets were clearly marked with pictures and bedroom doors had nameplates with people's name on. Such signage supported people who required prompting with knowing their immediate surroundings and how to find places such as the bathrooms. People were able to decorate their rooms to their taste, and were encouraged to bring in their personal possessions to give their rooms a familiar feel.

People had access to healthcare professionals including GP's, opticians, tissue viability nurses and chiropodists. Care records contained records of any multi-disciplinary notes which evidenced when staff had contacted them for advice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We did not see specific capacity assessments that had been recorded in care plans.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager acknowledged that this was a new area to them and they had liaised with the DoLS team to gain advice as to when to submit applications. The manager had submitted applications which were now being considered by the DoLS team.

Requires Improvement

Is the service caring?

Our findings

Not everyone at Collamere was able to verbally tell us about their experiences of living at the service due to their healthcare needs.

During both days of the inspection we spent time in the communal area of the service. Staff were kind, respectful and spoke with people considerately. One staff member found a person had spilt their drink on their clothes and said, "Oh that must be very uncomfortable, we must get you out of those clothes and cleaned up. I will go and get someone to help us." The carer returned a short while later with assistance to move the person to their room.

Throughout the second inspection visit most people were comfortable in their surroundings with no signs of agitation or stress. However, we observed two people who were calling out repeatedly for attention and assistance. There were not enough staff available to meet these people's needs. For example, there was one person who was very anxious, partially sighted and was sat in their bedroom at the far end of a corridor, calling out for assistance. We reviewed their care plan and it clearly informed staff of this person's social and care needs. It stated that the person needed assistance with their meals due to their poor sight and anxiety. They had been assessed as being at risk of, "Toppling forward." We saw this person was brought their meal in their room, this was placed on a table which could not be placed near enough for them to see and reach their food. Staff did not stay with this person to support them to eat. The inspector watched the person reach forward to try to reach their food. This led to them potentially toppling forward out of their chair. We needed to intervene and moved the food nearer to the person so that they were able to eat independently. They told us, "I am so frightened and lonely, please don't leave me alone, I can't see you now. I can't even see your face." This meant staff were not meeting this person's needs and the person was placed at increased risk of falling when unattended and reaching for their meal. We asked if this person could be taken to the dining room to eat at a table in the company of others, which they clearly enjoyed. We were told they could not as they were inclined to, "Fiddle with their (continence) pad and that upsets the others." This meant that the person was not encouraged to eat their meals with other people in the service which could lead to social isolation. In addition it provided a message to staff that it was easier to manage this person by withdrawing them form others and did not consider this person's care and emotional needs.

This contributed to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dignity was not always respected. For example, moving and handling equipment such as handling belts were not always used appropriately leading to people's clothing being lifted up exposing their underwear. Handling belts should be used to help a person who can stand and feel secure during a transfer as care staff use the belt to keep them supported when standing, it is not a lifting aid.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's bedrooms contained some items that were important to them, and which were reminiscent of their past. This helped their bedrooms to have a familiar feel.

Privacy was provided for people when care staff provided personal care. People told us "The staff are very kind .The curtains are drawn and the door closed when they wash me." A relative told us, "Once when I was visiting, the staff needing to change a pad, I was asked if I wanted to pop out of the room, I didn't mind. I've noticed they always shut the door and close the curtains when they need to do things that need privacy. They speak nicely to both of us."

People were supported to maintain relationships with family. One person told us "My visitors, my family are what's important to me, they come often, and they bring the dog." Visitors were always made welcome and were able to visit at any time. Staff were seen greeting visitors throughout the inspection and chatting knowledgeably with them about their family member.

People's life histories were documented in some care plans. This is important as it helps care staff gain an understanding of what has made the person who they are today. However, one person had arrived to live at Collamere a few weeks earlier and was living with dementia. Their care plan did not have this information completed. This meant staff were not provided with useful information on which to base any conversations or suggest relevant activities they might enjoy.

Requires Improvement

Is the service responsive?

Our findings

Care plans contained a large amount of information. The care plans detailed people's care needs. However, they varied in their level of detail and information to guide staff on how to support people. For example, one care plan stated that a person, "Wants things a certain way." However, there was no information for staff on what that 'certain way' was. One member of staff told us, "I know her well, we get along fine mostly. However, we have a lot of new staff and bank staff and I have to help them to know how (the person's name) likes things to be done. They get really cross if things are not done as they like." Staff told us that another person bit them and tried to scratch their eyes if they got too close. This was not reflected in their care plan. There was no risk assessment to help protect staff from injury.

As raised in the safe section of this report, staffing levels did not take into account staff time when a person became anxious. Some people living at the service were living with dementia and were calling out repeatedly for some time with no response from staff. The inspector went to find some assistance for a person in the lounge who was calling out. The member of staff who we spoke with told us, "They are not on my side, I don't do them." The staff member meant that the person's bedroom was not in the part of the building that they had been assigned to. Other care staff arrived 10 minutes later to move the person to their room. This is an example of institutionalised practice and was not person centred.

One person's care file showed many weeks of staff reporting that the person was shouting out a lot throughout the day and night. Staff told us such concerns had been, "Going on for as long as I can remember, they get really angry and shout at everyone and anyone. We have to put them in their room to stop other people getting upset." We had received information of concern that this person's needs were not being met. The care plan showed that the service had not sought any medical review of this person to try to address why they may be shouting out. The last entry in the multi-disciplinary notes was in 2015. However, a senior member of staff had then asked the person's GP to review them on 1 November 2016. This review had led to their pain relief being reviewed. At the second day of our inspection visit this person was asleep continually from our arrival at 10.00 am until 1.00pm with no signs of distress. It was of concern that the person did not receive a review of their care needs and subsequent actions, for such a long period of time.

We noted that guidance provided to staff was not consistently carried out. For example, care plans directed staff to weigh people regularly where there had been concerns about a person's food intake. Weight records were kept for 11 people. However, we found inconsistent practice in the recording of these weights. For example, one person was to be weighed daily due to concerns about their health. We found that in one month there were three gaps where the person's daily weight had not been recorded. On the monthly weight record sheet we found that the names of individuals to be weighed monthly changed each month. We were unable to clarify if this was because weights were no longer needed for particular people, if they had left the service or if they had been missed. Therefore, we concluded that the monitoring of the weight of people that were at risk of weight loss was not being carried out adequately.

At the inspection in August 2016, we identified that people had been assessed as at risk from developing skin damage due to pressure. Pressure mattresses were in place for these people. However, the mattresses were

not monitored to ensure that they were correctly set for the person using them. On the first day of this inspection, the manager said they completed their own audit and confirmed that some settings had been incorrectly set and had put them to the correct setting. The manager said they needed to're-educate' staff in this area. However, they had not kept records of when they checked the pressure mattresses or when the check needed to be repeated or what action they had taken with staff. On the second visit of this inspection, we reviewed four pressure mattresses and found that two were incorrectly set for people's weight. One was set for a person weighing 115 kgs when they weighed less than half that. Mattresses should be set to the weight of the person using them to ensure the risk of pressure damage to their skin is reduced.

We concluded that whilst weight charts were in place they were inconsistently completed. This meant staff were not provided with adequate information on which to base the correct setting for a person's pressure relieving mattress.

We were told that 10 people were on food/ fluid charts at the service. We reviewed these care plans, including the section for people's diet and nutrition needs, which we found were completed inconsistently. In one care file this section was blank. In another it said the person was to have their food 'cut into small pieces', then on another sheet of paper it said 'soft diet'. The manager confirmed that the person was on a soft diet and the previous care plan should have been archived. This meant it was not clear to staff what action was to be taken to meet people's dietary needs.

Staff completed what amounts of food and fluid had been given to people, but with the exception of one case there were no records of output of fluids. Where the fluid chart had recorded the maximum amount of fluids a person should receive, this had been exceeded by a 100mls. There was no guidance on what to do if a person exceeded the daily recommended amount of fluids. Fluid charts were being photocopied by staff and times and dates were missing. For example, staff had written drinks had been provided but no amounts of fluid had been recorded, and in some cases the amount of fluids consumed had been amended and was unclear. One fluid chart showed drinks were given at 9am, 11 am and 8pm but no evidence of any being given between 11am and 8pm.

We concluded that it was not possible to establish if people who were on a food and fluid chart, were receiving an adequate intake of food and drink from these records. Care staff were not sure when they had to complete the records or the reason for completing them. Staff told us they felt they had to complete them to "Prove we have given them (the person) a drink". On asking the manager why charts were in place, they told us "Because we are monitoring they are getting enough to eat and drink". However the total amounts of food and fluids were not being tallied each day. Therefore there was no monitoring of the person's daily intake of food or fluids which would identify if further action from staff was needed. This was raised with the managers in our August visit and we found no further improvements in this area had been implemented. We discussed these inconsistencies with the manager and deputy manager and they acknowledged that further information about why staff needed to complete these charts accurately was required.

We concluded that the care plans did not direct, inform and guide staff in how to meet a person's physical and emotional needs. Therefore this is a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the August inspection, families were concerned that there was not enough for people to do during the day. At this inspection people, relatives and staff were positive about the changes in the level of activities that were now provided at the service. The manager had recruited an activity coordinator, 4 days a week for 4 hours. A poster was on display advertising the activities on offer. The activities coordinator also spent time individually with people in their rooms. Detailed notes of the activity provided, who participated in the

activity and their response to the activity was recorded. We saw activities being provided in communal areas and a number of people chose to join in the activity provided. We spoke with the activity coordinator who told us that they also spent individual time with people, especially with those who spent all their time in their bedrooms.

People and families were provided with information on how to raise any concerns they might have. Details of the complaints procedure was contained in the pack provided upon admission to the service. Where concerns had been raised with the manager they had been responded to appropriately. Since the August inspection we have received four concerns from various sources. It is of concern that people did not feel able to address their issues with the service directly as they felt they would not be listened to and action would not be taken to address their concerns.

Inadequate

Is the service well-led?

Our findings

The service is required to have a registered manager in post. At the time of our inspection, there was no registered manager in post. No application for this post had been received by the Care Quality Commission. A new manager had been in post since April 2016.

Since March 2015 we have regularly asked the provider to tell us what action they intended to take to ensure there was a registered manager at the service. In March 2015 a new manager was appointed and was registered with the CQC. In September 2015 the registered manager started a new role as the clinical lead for this service and three other services. This person oversaw the running of Collamere plus being the clinical lead for the other services. In October 2015 a new manager was appointed but left in January 2016. In April 2016 a new manager was appointed but to date we have not received a registered manager application for this service.
These changes in the management of the service have meant that the leadership of the service has been inconsistent. This also shows that the provider had repeatedly failed to retain managers long enough for them to become a registered manager. The provider has failed to recognise the risk to the quality of the service provided to people due to not having consistent management.

At our August inspection we found systems were not being operated effectively to assess and monitor the quality of the service provided. At this inspection we found there was no robust system of effective auditing in place and therefore the provider and manager were unable to identify or address any areas of concern. For example, at the August inspection we found that pressure mattresses were not at the correct setting for people's weight. The manager said they completed their own audit and confirmed that some settings were incorrectly set. However, they had not kept records of when they checked the pressure mattresses or when this check needed to be repeated or what action they had taken with staff. To add to this concern we found that whilst weight charts were now in place, they were inconsistently completed. This meant staff were not provided with adequate information on which to base the correct setting for a person's pressure relieving mattress.

We found many records were not up to date. These records had been highlighted at the previous inspection, yet still there was no induction documentation in place nor had the training matrix been updated. We also noted that actions we identified at the inspection in August 2016 and needed to be put in place had still not been addressed. For example, no action had been taken to ensure that staff double signed handwritten entries of new medicines on MAR sheets.

Records for specific care practices were inconsistently kept. For example, there were no guidelines for staff in how to administer 'as required' medicines. We also identified that food and fluid charts and people's weights were not being completed consistently. This meant that staff did not have the information, guidance or direction about when to provide certain elements of care to a person or what action to take if a person's health needs changed.

We identified there were difficulties in communication within the management team. Following the previous

inspection the head of operations had come to the service and commenced their own care plan audit. This was a handwritten document at the front of the person's file, which was not signed or dated. Nursing staff did not know what the form was for and if they needed to take any action. The manager had also introduced their own care plan auditing system which they had shared with nursing staff on how they wanted it to be completed. This demonstrated that there was no agreement between the head of operations and the manager as to how they would respond to an issue. This created both confusion for staff and evidenced that there was no agreement of how specific actions were to be taken.

The manager had designed a new handover recording sheet to improve communication between staff. The handover sheet was to be used at shift handover so that any changes to care, or any actions needed to be taken were recorded to reduce miscommunication between staff. We found used sheets were not dated or signed and were put together in a folder unfastened. Therefore, it was not possible to audit the information that had been handed over to staff on specific shifts or for staff to refer back to what action they may need to undertake that day. This meant it was not possible to establish what information about people's care and support needs had been shared. This was a concern that had been previously highlighted by the Quality Assurance and Service Improvement team at Cornwall Council and was an outstanding item on their action plan.

People were at risk of receiving inconsistent care because the service had staff vacancies and most days and the majority of evenings there were bank workers on duty to cover for those vacancies. The manager was able to request bank staff when necessary although it was the registered provider who arranged this. The manager had no control over which bank worker was booked as they were not able to request a specific worker or workers. This meant the manager could not ensure that people received care from staff who had the right skills and knowledge to meet the needs of people living at Collamere.

There were no effective processes in place to monitor the quality of the service provided. The manager held their first residents meeting in October 2016 but action raised from that meeting had still not been implemented. For example, the provider agreed to bring a hot plate for food to the service on the 10 October. People using the service raised the issue of food being cold before it reached them as a continued issue, in the residents meeting of the 26 October 2016. To date the hot plate was still not in place. This meant that the service was not effectively seeking or responding to people's views and experiences of the service provided and taking any action that may be needed to improve the service.

We noted that the most recent inspection report was not accessible to people in the service. Following the previous inspection we requested that the provider submit an action plan on how they would address the shortfalls of their service. To date we have not received one. From the issues highlighted in the previous and in this report, it is of concern that the management team have not openly shared with us how they intend to address the failings of their service.

People's personal confidential information was not kept securely on our visit in August 2016. We found on our visit on the 10 October that the office was locked, however on our return visit it was again unlocked. This meant that personal confidential information was not stored securely.

We have therefore concluded that systems in place were used inconsistently and that the level of communication was not effective. The evidence above demonstrated the provider's on going breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

At the August inspection staff reported concerns about the quality of the laundry service at Collamere. We looked at what action had been taken to address these issues. Staff told us "It's awful. We come in early to

get the laundry done otherwise we would not have enough clean bedding".

We toured the service and found lumpy, uneven pillows in six bedrooms, two had bloodstains on them. The registered provider said they went lumpy as staff dried them in the tumble drier. However they would not be comfortable to use. In one room we looked under the quilt and found there was no base sheet. We were told this was because there had not been enough laundry and it was being washed and dried. A sheet was later found in the room which was torn at the end. The manager told us this happened because staff pulled sheets away from metal bedframes which ripped them. When we visited the laundry at 15:30 we found four sheets laundered and available. There were a number of sheets being laundered by staff because they said the laundry assistant only worked three hours a day which was not enough. Six sheets were being dried so there would be enough available for staff to use.

We took a sample of a 'lumpy' pillow, two hand towels that were frayed and discoloured due to extensive laundering and a torn bed sheet to show the registered provider, manager and deputy manager. Their response was to place blame on staff for drying pillows in the tumble drier and for taking new towels. None of the management team had taken action regarding the laundry issue even though they had been made aware of this during the feedback from the inspection in August 2016.

This is in breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014.

We noted that staff, people and relatives were positive about the appointment of the new manager. Staff told us that, "Things have improved although there is still a way to go." Staff meetings took place. These were an opportunity to keep staff informed of any operational changes and for staff to voice their opinions or concerns. However, minutes of these meetings were not available. Both the manager and the deputy manager regularly worked alongside nurses and care staff providing care to people. This meant they were aware of the culture of the service at all times.

The manager was supported through supervision with the head of operations and regular meetings took place with the managers of the other services in the Morleigh group.