Mosaic Community Care Limited

Southwold Nursing Home

Inspection report

Southmoor Road,
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Date of inspection visit: 20 and 23 January 2015
Date of publication: 25/06/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection was carried out on 20 and 23 January 2015 and the first day was unannounced. This means we did not give the provider prior knowledge of our inspection. The provider became legally responsible for the home in April 2014 and this was the first inspection we had carried out since ownership changed.

We carried out this inspection in response to concerns raised regarding the staffing provision at the home and also concerns regarding the care and welfare of people who lived at Southwold Nursing Home.

Southwold Nursing Home is registered by the Care Quality Commission to provide accommodation and nursing care and support for up to 41 older people. The home is located in the Wythenshawe area of Manchester. The home is situated across two floors with lounge facilities on both floors and dining facilities on the ground floor. Each floor has bedrooms and small lounge areas known as bays. The first floor is accessed by a lift. The home is a large detached property set in its own grounds with off road car parking available.

Summary of findings

The registered manager left the home in December 2014. We were told the home was currently recruiting a clinical lead to provide additional support and guidance and the clinical lead would be applying to become the registered manager. The registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of the inspection the home was being managed by a care manager who was being supported by two senior managers of the provider's management team. These were the registered manager of another home owned by the provider and the head of mental health and learning disability services of a domiciliary care agency. This agency was also owned by the provider.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on the 1 April 2015. These were in relation to the care, welfare and safety of people who lived at the home, the numbers of staff available to meet their needs and the support available to staff. In addition breaches were found in as insufficient quality monitoring checks at were carried out, people told us they were not involved in their care and we saw care documentation was not accurate and easily understood. CQC is considering the appropriate regulatory response to resolve the problems we found.

People who lived at Southwold Nursing Home told us they often had to wait for staff support if they required assistance. We saw staff were busy and we heard call bells ringing excessively before support was offered. Some relatives we spoke with also voiced concerns regarding the number of staff available to meet people's needs in a prompt manner.

We observed staff supporting people to eat and saw this was not a positive experience for some people who lived at the home. We observed staff supporting two or more people at the same time to eat a meal and we observed that this did not uphold people's dignity or enable a relaxed and positive environment for people to dine.

The care records we viewed did not contain up to date and accurate information regarding the needs of some people who lived at the home and we also found people's current health care needs were not always assessed to ensure they received care which met their needs. This meant that people were placed at risk from inappropriate delivery of care.

We observed a lack of leadership within Southwold Nursing Home. We spoke at length with the care manager and were told there were no documented audits carried out to monitor care records or the quality of care people received. In addition the manager did not monitor or act upon the absence of staff, we saw no evidence of meetings for staff, relatives or people who used the service. The lack of monitoring meant risks were not identified and action was not taken to improve the care, welfare and experiences of people who lived at the home.

Staff we spoke with told us they had received training in areas such as safeguarding, moving and handling, fire safety and the Mental Capacity Act 2005. However we were unable to view documentation that confirmed this. The manager told us qualified staff had not received clinical supervision since October 2014. The qualified staff told us they received little leadership from the care manager and we found improvements were required to ensure the home was well-led.

People and their relatives told us they were not always involved in the care provided and the complaints procedure was not used effectively to ensure complaints were monitored.

We found medicines were not always administered in a way that assured people's safety.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Staffing was not arranged to ensure people's needs were met in timely manner and this placed people at risk of harm or injury.

Staff we spoke with could explain indicators of abuse and the action they would take to ensure people's safety was maintained. However staff did not identify and respond to risk appropriately.

Medicines records were incomplete and fridge temperature monitoring was not carried out.

Inadequate

Is the service effective?
The service was not effective.

Staff did not receive supervisions to enable them to identify any learning needs or seek clarity on their responsibilities.

People's health needs were not always assessed or monitored to ensure care met their needs.

Inadequate

Is the service caring?
The service was not caring.

People told us they felt cared for however we observed people were not always treated with dignity and respect.

People were not always involved in their care.

Some people received very little attention and interactions with them were task focussed.

Requires improvement

Is the service responsive?
The service was not responsive.

A complaints system was in place; however this was not used effectively.

Some people did not receive personalised care at the time they required it and activities were not always available for people to participate in.

Inadequate

Is the service well-led?
The service was not well-led.

There were insufficient monitoring checks being carried out to ensure any shortfalls were identified and improvements made.

Staff did not feel supported and our observations showed us there was a lack of leadership at Southwold Nursing Home

Inadequate

Summary of findings

Care documentation was inaccurate and did not reflect people's needs.

Southwold Nursing Home

Detailed findings

Background to this inspection

We carried out this unannounced 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.

Prior to the inspection we reviewed notifications that we had received. In addition we spoke with a commissioner at the local authority, who visited the service. They told us they were working closely with the home to ensure improvements were made.

This inspection was carried out on the 20 and 23 of January 2015. On the first day of the inspection two adult social care inspectors and a specialist advisor who had experience in nursing was present. A specialist advisor is a person who has specialist knowledge and experience. On the second day of the inspection one adult social care inspector was present.

During the inspection we spoke with seven people who lived at Southwold Nursing Home, five relatives, eight care staff, two apprentices, four qualified nurses and the chef. We spoke with the care manager, the provider's head of mental health and learning disability services, a visiting manager from the providers other establishment and two external visiting health professionals. We also observed the interactions between staff and people who lived at Southwold Nursing Home and looked at all areas of the home, for example we viewed lounges, people's bedrooms and communal bathrooms. At the time of the inspection there were 36 people resident at the home.

We looked at a range of documentation which included four care records, five staff files and a recently completed medication audit. We also looked at a sample of medication and administration records.

Inadequate

Is the service safe?

Our findings

Overall, people told us they felt safe. Comments we received included; “None of the staff would hurt me, they’re really nice but they need more of them.” “I’m safe here.” And “I feel safe, the girls are very kind.”

We asked four staff members to explain their understanding of abuse. We asked staff to give examples of abuse and the staff we spoke with were able to describe the types of abuse that may occur. They were also able to identify the signs and symptoms of abuse and how they would report these. All the staff we spoke with told us they would not hesitate to report concerns and told us they had received training in the safeguarding procedure. We were told; “I would report straight away.” “Reporting helps protect people.” And “I wouldn’t be afraid to report anything, the training was good.” It is important that staff know and can recognise signs and symptoms of abuse in order that concerns can be reported promptly and investigations carried out as required.

During the inspection we saw that wheelchairs were not always used safely. We observed a staff member moving two people in wheelchairs and we saw that they left them in the lounge without the brakes applied to the chairs while the staff member collected hoisting equipment. There were no other staff in the immediate area. Brakes should be applied to wheelchairs when they are in use and stationary to ensure movement does not occur that may result in injury or harm to people.

During the inspection we saw staff did not always respond to risks and this placed people at risk of harm. During the inspection we heard one person calling for help. We visited them in their room and saw they were banging their spoon against their breakfast bowl and saying, “Here, come here.” We asked them if they needed any help and they told us; “I can’t find my bell, it’s not where it usually is.” We observed the call bell to be between the bed and their wall and they could not reach it. We discussed this with the qualified member of staff who told us they believed the night staff had not returned it to the person. This placed the person at risk as they were unable to summon assistance if they required it.

We saw that this person had bedrails in place. These are used to minimise the risk of falls that may cause injury. We saw a bumper cover was in place on one bedrail but not on the other. Bumper covers are used to ensure the risks of entrapment and injury are controlled. We pointed this out to a qualified member of staff who told us they did not know where the bumper was, they thought the night staff had removed this and it had been taken to the laundry. We also asked three care staff if they had removed the bumper and were informed they had not. Staff had not responded appropriately to minimise the risk of harm to the person as the lack of a bumper cover placed the person at risk of injury.

The above examples demonstrated a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and support was not delivered in way that ensured the welfare and safety of people who lived at the service.

We saw a bedrails risk assessment had not been completed for someone who was using these on the day of the inspection. Risk assessments are important as they assess and identify risk and introduce control measures to ensure risk is minimised. The lack of an assessment placed the person at risk of harm or injury. At the time of the inspection this was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed staffing with the care manager. When asked, the care manager could not tell us what system they used to ensure there was enough staff to meet people’s needs. They told us they did not think there was a formal assessment tool used. The care manager stated that during the day it would be usual to have five carers and one qualified staff on the ground floor and one qualified staff and four carers on the first floor. The night staffing provision we were informed was normally one qualified staff member and five unqualified carers. At the time of our inspection we were told there were 36 people resident at the home.

On both days of the inspection we were told that not all staff had attended for their shift. The care manager obtained additional staffing by asking activities co-ordinators to deliver care and contacting permanent staff to cover the shift. We asked the care manager how they monitored sickness, non- attendance at work and

Is the service safe?

lateness. The care manager told us they did not carry this out but it had been planned for a member of the provider's senior management team to visit the home within the next week to offer support and guidance with this. The care manager told us if staff did not attend for work permanent staff, bank staff or agency staff would provide cover.

Through our observations of staff and our conversations with people and relatives we found there were not enough staff to meet the needs of people who lived at Southwold Nursing Home. All the people we spoke with expressed their dissatisfaction with the number of staff available to support people. Comments we received included; "Yesterday I had to wait over an hour for someone to come when I rang my bell – I was desperate for the toilet." "The longest I've ever waited – you won't believe me is an hour.", "It takes ages for them to come, sometimes I have to shout and eventually they do arrive but I don't think it should take half an hour for them to get to me at my age."; "If I need help I press a button and they take ages to come. I've had to wait for nearly an hour once – I got a bit scared really." When we asked them why they were scared they told us; "If it was urgent I could die." We asked them why they felt that way and were told it was because if they became unwell staff would not respond to them quickly. One person told us they had to book a shower in advance as if they did not, staff were too busy to support them.

Three relatives we spoke with also said they believed more staff were required to meet people's needs. We were told; "My (family member) has had to wait in excess of 20 minutes more than once." Staff are too busy to do anything but the basics."; "I don't think they're looked after enough, there's not enough people here to do that."

During the inspection we found staff were happy to speak with us, however this was sometimes difficult as they were supporting people with care. Therefore we arranged with staff that they would approach us when they were able to do so. On speaking with them we received conflicting feedback regarding the staffing levels at the home. We were told; "We need more staff to give extra care but the basic care is met." "We probably need more staff as people have complex needs."; "We don't have the time to give quality time. It's just about getting them in and out, not about that five minute conversation that makes their day."; "We don't have to rush people."; "I feel constantly concerned because the residents need care, because the staff rush and I want them to be given time."

During our observations we saw people who required wheelchairs were brought to the dining room for breakfast and on finishing their meal they were taken to the lounge and remained in their wheelchairs. We asked a staff member to explain why this was so. We were told; "We don't have enough staff to move people into comfy chairs after breakfast. We wait until after lunch because then staff aren't on bays getting people up, so there's more of us."

In addition we viewed a rota, which showed us on five occasions the staffing numbers set by the provider had fallen below the number described by the care manager. We discussed this with the care manager who confirmed the rota was correct. They told us they had been unable to obtain staffing cover.

We also spoke with two visiting health professionals who told us they sometimes had difficulty in finding staff to support them while they visited and the staff were often very busy. We discussed our concerns with the head of mental health and learning disability who told us they would discuss this urgently with the owners of the home.

We spoke with one person in their room. We saw they had bedrails in place and they confirmed this was their choice. They told us they could not get out of bed unsupported and they stayed in their room as there were insufficient staff to support them with their mobility to attend the lounge. We viewed the person's care file and saw they had been assessed for an electronic wheelchair and the person confirmed this. They then said; "I'd like to use my wheelchair when I want but (the staff) say they're busy so I don't ask." The care records we viewed contained a health professional's recommendation that the person would benefit from spending time out of bed. We also spoke to a visiting health professional who confirmed this would be of benefit for the person. The staff we spoke with told us they did offer the person the opportunity to get out of bed, however none of the staff we asked with could recall the last time this had been offered or when they had last supported the person to do so. We discussed this with the care manager who confirmed there was no medical reason why the person could not spend time in other areas of the home. On the second day of the inspection we spoke with the person who told us (that since the first day of inspecting the home,) staff had supported them to spend spent time in the lounge and they had enjoyed this. This is important as people should be empowered to retain their personal freedom and independence. However, our

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Is the service safe?

observations and the feedback from the people we spoke with during the two days of the inspection showed us that the number of staff available was insufficient to meet people's needs.

At the time of the inspection this was a breach of Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were insufficient staff to support people in a way that promoted their independence and met their individual needs.

During this inspection we checked a sample of medication and administration records (MAR) and saw the record and amount of medicines on site matched. This showed us medicines were available and the medication had been administered as prescribed. We also checked to see that written protocols were available if people were prescribed as required (prn) medication. These are important as they inform staff when and why a person may need, as required medication. In two of the files viewed we saw no protocols were in place.

We checked to see that liquid medication was dated on opening. The medication we viewed was dated and was within the recommended expiry time. This is important as medicine administered 'out of date' is less effective and therefore may not produce the desired effect. We discussed the arrangements for ordering and disposal of medication with a qualified member of staff. They were able to explain the procedures in place and we saw medications were disposed of appropriately by returning them to the pharmacist who supplied them.

We saw the fridge temperature was not monitored to ensure medication was stored at the correct temperature. The document we viewed had not been completed since December 2014. This meant that staff could not be sure that medicines were always kept at the correct and safe temperature. The correct storage of medication helps ensure the medication is effective.

We observed a qualified staff member staff administering medication and saw they spoke to people before this was given to them. They explained what the medication was for and asked if they were ready to receive it. When people consented we saw the staff member checked the MAR and then checked the medication before giving it to the person. During our observation we saw the MAR was signed on administration. This helped ensure accurate records were maintained and minimised the risk of medication errors occurring. However we saw the qualified nurse was interrupted on six separate occasions due to answering the phone and responding to queries from staff. It is important that distractions are minimised when medication is given as failure to do so may result in a medication being incorrectly administered or recorded.

We were informed by a qualified nurse and the care manager that the medicines sometimes took up to three hours to administer. We saw and were told by a qualified staff member that staff did not record the actual time medicines were given to people if different to those printed on the MAR. This meant that people were at risk of receiving medicines too close together and medicines may not be as effective, or may result in harm.

We also observed there were gaps on Medicines and Administration (MAR) records. We saw one person's MAR record, which had not been signed to indicate if a person had received their 'as required' medicines for seven days. In addition we saw a MAR record for a further person, which showed they required eye drops but there were gaps on the MAR we viewed. We noted two days where there were no entries on the MAR to indicate the medicines had been given or offered.

On the day of the inspection we saw a gap in the MAR record of a further person and were informed by the qualified nurse the medicines had been given but not signed for on the MAR. Medicine records should accurately reflect the medicines given as this helps ensure people receive their medicines safely, when they need them and minimises the risk of the harm.

We discussed our concerns with the care manager who told us a new medication system was being introduced within the next week and this would minimise the risk of errors. However during the inspection we considered arrangements were not in place to ensure medicines were administered safely. At the time of the inspection this was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not managed safely.

We asked staff to describe the process that had taken place when they were recruited to the home. We were told staff

Inadequate

Is the service safe?

had attended an interview with the previous manager and had completed Disclosure and Barring Checks (DBS) checks prior to starting work at the home. In addition references were obtained to ensure people were suitable to work at Southwold Nursing Home. We viewed five personnel files which showed us there was a process in place to ensure people were safely recruited to work at the home.

Inadequate

Is the service effective?

Our findings

All the people we spoke with said they were happy with the meals provided. They described the food as; "good", "palatable" and "generally good."

We spoke with the cook and saw if people required a specific diet, this was displayed within the kitchen. The cook told us this was to ensure the correct meals were provided to people who required this. We also saw a menu was displayed and the cook told us if people requested an alternative this was provided. We viewed the fridges, freezers and storage areas of the kitchen and saw there were sufficient supplies to enable meals to be provided. We saw there were fresh vegetables and fruit and on the day of the inspection we saw fried fish, salmon and jacket potatoes were available. The cook told us they would also prepare meals on request, for example if a meal was declined they would prepare simple meals such as omelette, sandwiches, soup or cheese on toast.

Prior to the inspection we had received information of concern that people were not supported to eat sufficient amounts to meet their needs. We observed the lunchtime mealtime at Southwold Nursing home and saw this was not a positive experience for all the people who lived there. We saw one person was given a meal and they expressed their dissatisfaction with the meal provided and did not eat it. We saw they were not offered an alternative. We discussed this with a member of the care staff who offered the person an alternative, which they declined.

The atmosphere during lunch was busy and noisy. The television was playing loudly in the lounge and staff were seen to be shouting to each other in the corridor. We saw one member of the care staff shout to a housekeeper regarding some cleaning that required completing. We also saw the chef leave the catering area and shout across the dining room to a carer; "Does (person) want a pudding." It is important that people enjoy the dining experience as this encourages people to eat and drink enough to meet their needs. We discussed our observations with the care manager and the head of mental health and learning disability services who told us they would address this immediately by contacting the owner of the home.

We observed tea, coffee and biscuits were provided throughout the day to people who lived at Southwold Nursing Home and in addition to this cold drinks were also available. It is important that people receive adequate nutrition and hydration to maintain their wellbeing.

We visited one person in their room and saw they had bruising and dressing strips on their arm. They were unable to discuss this with us as they could not recall how this had occurred. Therefore we asked the care manager to explain how the person had sustained the injury. The care manager explained the person had returned from hospital with the injury and we asked to see the person's care record. In the care record we viewed we saw no care plan was in place to ensure staff were aware of the treatment the person required in relation to the dressing. We discussed this with the qualified nurse and it was a concern to us they were unaware of the injury. They later told us the dressing strips were due to be removed the next day. People's needs should be assessed and known by staff so the correct care and treatment can be provided. At the time of the inspection this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's needs were not assessed and care delivered to meet their individual needs.

We visited one person in their room and asked them their opinion of the care provided. They told us "Look at my nails, will you ask them to cut them?" We saw their nails were long with black matter under them. They told us they enjoyed a shower but they had not had one for a long time. We viewed their care record and saw the last recorded shower was in November 2014. We discussed this with the care manager who told us there was no health reason why the person couldn't have a shower and they would ensure their nails were cut. On the second day of the inspection we spoke with the person who showed us their nails had been cut and they were going to have a shower. They told us staff had said they would help them. However, we concluded improvements were required as prior to the inspection care had not been delivered to meet individual needs. At the time of the inspection this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care was not delivered to meet peoples' individual needs.

Inadequate

Is the service effective?

We looked at one care file and saw it had been identified by a visiting health professional that a person appeared to have visibly lost weight and they had commenced on food supplements. We saw the health professional had instructed the person should be weighed. We looked at the person's weight chart and saw they had been weighed after the health professional's visit. The last recorded weight prior to this was in November 2014. We saw the person had lost 8.5 kilograms and could find no evidence in the care record to show the person's weight loss had been identified by the home prior to the health professional's visit. We looked in the person's care record and saw the last recorded malnutrition assessment was carried out in October 2014 and the person's care plan stated the malnutrition assessment should be completed monthly. In addition the care plan stated the person should be weighed monthly and more frequently if the person lost weight and to liaise with other health professionals as required. The care manager could not explain why this had not been carried out or why the person's weight loss had not been noted. It is important that people's health is monitored and referrals made to other health professionals as required to ensure people receive care and treatment that meets their needs.

In the same person's care file we saw an instruction from a health professional requesting their blood pressure be checked every few days. In the care record we viewed we could not see any evidence this had been carried out. We discussed this with the care manager who was unable to offer an explanation, but showed us documentation that demonstrated this had been attempted and the person had declined. However this was not until just over three weeks after the health professional's recommendation. People should have their health monitored in accordance with professional's recommendations so treatment can be planned and delivered to ensure their welfare. At the time of the inspection this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's individual health needs were not collaboratively assessed and care delivered to meet these and ensure their care and welfare.

We viewed a further care file where we noted an entry which said "weekly weights to continue." We viewed the person's weight records and saw the last entry was in January 2014 and the records prior to this were not consistent with the person's needs. People should be weighed in accordance to their assessed needs to ensure care and treatment can be reviewed and adjusted to meet their needs. We discussed this with the manager who confirmed the person should be weighed weekly This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's individual health needs were not assessed and care delivered to meet these and ensure their care and welfare.

The CQC monitors the operation in care homes of the Deprivation of Liberty Safeguards

(DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA). They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We saw evidence within the records we viewed that people's capacity was considered when significant decisions were made. We asked staff to explain their understanding of the MCA and DoLS. Staff we spoke with had a good understanding of the processes in place to ensure people's consent was gained and if they were unable to consent, the steps that should be taken to ensure decisions were made in people's best interests.

We asked staff what training and development they had received to enable them to carry out their role effectively. All the staff we spoke with told us they had completed an induction which consisted of training in areas such as moving and handling, fire safety and safeguarding. In addition they were not permitted to work unsupervised until this had been completed. Staff also told us they received annual training in these areas and in the Mental Capacity Act and Deprivation of Liberty Safeguards. We asked staff when they had completed this and were told it had been prior to the change in ownership of the home. They said the training was still in date and they would be informed by the manager if further training was required.

We asked staff if they participated in one to one meetings with the manager to discuss their performance or if they had completed an appraisal. The staff told us they had not received supervision for two months. This was confirmed by the care manager who told us supervision meetings

were being planned for the coming weeks and another home manager would be providing clinical supervision for qualified nurses. The care manager told us qualified staff had not received clinical supervision since October 2014.

This was a concern to us as evidenced within this report; we had identified shortfalls in the performance of staff at the service. It is important that arrangements are in place to ensure staff receive supervisions as this enables training needs to be identified and helps ensure people receive care and treatment of an appropriate standard.

The care manager told us the home currently had apprentices in place. An apprentice is a person who is learning a skill from an employer. We asked how the care manager ensured apprentices received adequate supervision to ensure their learning needs were identified and they were able to deliver quality care. The care manager told us they did not complete supervisions with apprentices as the college were due to visit them, however the care manager acknowledged this would not ensure the quality of care they delivered was to an acceptable standard.

We asked to see evidence of completed supervisions for all staff and none was provided. We discussed this with the care manager and asked how they identified shortfalls in people's training and competence. The manager told us all staff training was currently in date and they would be completing a 'training matrix' to ensure they had an overview of the training needs of the staff. This would be part of the new computerised records system. We were also provided with some registers to evidence that apprentices had received recent training in moving and handling, fire safety and health and safety. In addition the care manager told us staff had taken part in recent training on end of life care, diabetes, medication management and dementia provided by a college and further training was planned. However at the time of the inspection we concluded improvements were required to ensure shortfalls in staff performance and training were identified and actioned.

These examples illustrated a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because suitable arrangements were not in place to ensure staff were supported to deliver safe and effective care to an appropriate standard.

Requires improvement

Is the service caring?

Our findings

People told us they felt cared for. Comments we received were: "Nothing wrong with the staff here at all, they're lovely and look after me." "Staff are alright." And "The girls are very kind."

We observed some interactions were caring. We observed one person was in their room and appeared anxious. We saw staff sat beside them and listened to their concerns. We also saw one person was having difficulty with their television remote control and the staff member supported them to use this. We also saw occasions when staff spoke with people in a compassionate manner.

However during the inspection we saw some people were given very little attention. For example we saw one person in a wheelchair asking staff for support. We saw staff pass them on five occasions before the support was offered. We also saw people were sat in the lounge, with the television on and staff interactions were task focussed. Staff did not sit with people or converse with them unless care was being delivered, such as giving drinks or supporting people with mobility.

Although we observed staff knocking on people's doors before they entered and on supporting people with personal care, doors were shut to ensure peoples' privacy was maintained; we also observed peoples' privacy and dignity were compromised at times. We observed staff talking about people while they were supporting them. We heard comments such as; "I don't think (person) ate their breakfast this morning." "(Person) doesn't like that." and "(Person) has just thrown food all over their room." People should be supported in a way that protects their dignity and upholds their confidentiality.

We saw some examples of poor practice at Southwold Nursing Home. We saw there were times when people were not treated with consideration and respect. We saw staff supporting people to mobilise and noted that staff did not always offer explanation or reassurance to the people they were supporting. We observed staff supporting people who used wheelchairs from the dining room to the lounge. We saw staff did not tell people what they were doing and moved people with no consultation or explanation of what they intended to do. In addition we saw people were left in their wheelchairs while staff left the area to collect a hoist. We did not see staff offer an explanation of where they were going, what they were doing or when they would return. In addition we saw when people were supported with a hoist, staff offered no reassurance. We saw two people being supported and noted staff did not explain what they were doing while they attached the hoist, when they used the hoist to lift people or while the hoist was being moved with the person in it. We did not see staff communicate until the person was lowered into the armchair. Staff then said; "It's alright, it's just straight down now."

Three of the relative's we spoke with told us they were not always informed of changes in their family member's health. They told us they considered the staff to be "lovely", "dedicated" and "kind." However they expressed their concerns that there were occasions when information was not passed to them. One person told us; "I'm only informed if I ask, they don't inform me and there's no meetings."

Comments we received from the people we spoke with also demonstrated people were not always involved in their care planning. Comments we received included; "They don't really talk to me about my care, no." "They tell me what they're doing but that's not the same as being involved really." "I'm not involved all the time." And "I don't recall being asked about my care plan."

During the lunchtime meal although we saw people were supported to eat and drink, we saw this was sometimes carried out in a way that did not uphold peoples' dignity. We saw staff were not always attentive to people they were supporting to eat. We observed one person being supported by one staff member who stood with their hand on the back of the person's wheelchair whilst helping them with their meal. We also saw staff left people while they were supporting them. We observed staff leave one person, without explanation to assist another person with their lunch and until they returned the people they had left could not eat or drink. We saw this situation was repeated for three other people who required support to eat. We considered that improvements were required as people were not treated with dignity and respect.

These examples illustrated breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not treated with consideration and respect.

Inadequate

Is the service responsive?

Our findings

During the inspection we were told by the care manager the home provided activities for people to participate in if they wished. We also spoke to two members of staff who told us they provided activities such as film afternoons, card making and sing-songs. During the inspection we did not observe any activities being carried out. We looked at the activities noticeboard and this contained no information on activities available for people who lived at the home. One person told us activities were often cancelled as activities staff were sometimes required to support people with care. This was confirmed by the care manager. The person we spoke with told us; "I do get bored but I mustn't complain." The care manager told us records of activities were kept, therefore we asked to view these. During the inspection we were not provided with evidence to demonstrate activities were carried out with people who lived at Southwold Nursing Home. It is important people are encouraged to engage and participate in activities that are meaningful to them as this may improve peoples' quality of life and encourage independence.

The relatives we spoke with told us they would raise any complaints they had with staff. Staff confirmed they would pass this to the care manager.

We asked the care manager to explain the complaints procedure to us. The care manager was vague in their response and said if people who lived at the home, or relatives, made a complaint they would address this with them at the time. We asked the care manager to provide us with records of complaints and were told these were not documented. When we asked them how many complaints they had received since they had been care manager they were unable to tell us. We asked to see the complaints procedure and saw this contained processes to ensure complaints and minor concerns were recognised and documented. We concluded the system in place for the responding to complaints was ineffective as it was not being followed. It is important that any concerns or complaints are fully investigated to ensure shortfalls are identified and improvements are made whenever possible. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the care manager what provision was in place for people who requested an advocate. They told us they thought someone at the home had an advocate but on further discussion they also told us they did not know if there was an advocacy provision at the home and they told us they did not have any information to give to people about how they could find one. We saw a notice was displayed on a public notice board advising of a local advocacy provision; however it was a concern to us that the care manager was unaware of this service. This meant people may not be aware of advocacy services which are available to them. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the care manager how people were involved in developing their care plans and we were told this was the remit of the qualified staff. The care records we viewed had not been written in a person-centred way. We saw entries that did not place the person at the centre of their care and was not written from their perspective. For example we saw one entry that said "(Person) now to be got up." and "Ensure (person's) face is cleaned after meals." In another record we saw a person was called two different names, none of which were their correct name. The records contained limited information regarding people's preferences. For example there was little information to guide staff on people's personal preferences such as preferred food preferences or social activities. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's dignity was not protected and their independence promoted.

We viewed one person's care plan and saw it instructed they should be repositioned every two hours to maintain their skin integrity. We looked at their positional change charts and saw this did not always occur. We saw seven occasions when the person had not been repositioned in accordance with their assessed needs.

We looked at a further person's positional charts and saw these showed they were not receiving care and treatment in accordance with their needs. We asked to see the person's care plan and saw it stated the person should be

Inadequate

Is the service responsive?

repositioned every two hours. We asked for their positional change charts and viewed the charts provided. We saw there were no entries between 11pm and 8:30am. This indicated the person had not been repositioned between these times. We saw a further chart that indicated the person had not been repositioned for almost 10 hours. It is important people are repositioned in accordance to their assessed needs to prevent harm or injury.

We concluded care had not been delivered in response to assessed needs and at a time when it was required. This placed the person at risk of harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the care manager if meetings were held with relatives and people who lived at the service to identify if changes were required to improve the service the home provided. We were told no meetings had been held since September 2014. The staff and relatives we spoke with confirmed they had not attended any meetings and one relative told us “I have requested it.” In addition we were told no quality assurance surveys had been carried out. However the care manager informed us a survey had recently been distributed to relatives. People who use the service and those that are important to them should be empowered to give feedback to enable shortfalls to be identified and changes made to improve the experiences of people who live at Southwold Nursing Home. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the time of the inspection there was no registered manager in post and managing the regulatory activity. We were informed by the care manager the registered manager had ceased to work at Southwold Nursing Home in December 2014 and recruitment was taking place. The provider of the service had contacted us regarding this.

We asked the care manager to explain their role to us. The care manager told us they were currently managing the home until a clinical lead could be recruited and the clinical lead would be registered with the CQC as the registered manager. They also told us they received support from the provider's senior management team. In discussion we learnt a registered manager from another of the provider's homes visited on a weekly basis as did a training manager.

We asked the care manager to explain what processes were in place to ensure staff received guidance and direction. The care manager told us they attended 'handovers' whenever possible. We discussed this in more detail and learnt that since the registered manager had left, there had been no staff meetings or one to one meetings with staff. The care manager told us they did listen to staff and respond; they told us they had received a concern from a member of staff that overtime was not being allocated fairly by the staff member responsible for the staffing rota. The care manager told us and we viewed a letter to staff which showed us, the care manager would now be completing the rotas.

We asked the manager to explain how they monitored the overall management of the home, for example monitoring lateness, sickness, weight loss and quality of care. The care manager told us they had not reviewed sickness, held back to work interviews or monitored lateness. We were informed this would commence within the next week, with support from a member of the senior management team. We asked if checks were carried out to monitor the quality of care and staffing on nights. The manager told us they did not have a key to enter the home at night, and did not want to ring the bell as this would alert staff to their presence. We concluded improvements were required to ensure any shortfalls in staffing performance were identified and actioned to ensure performance was satisfactory.

We discussed our concerns regarding a person's weight loss with the care manager and asked if they maintained an overview of people's weight loss or gain to ensure any trends were identified and action taken. The care manager told us they did not maintain an overview or monitor people's weight loss but the introduction of the computerised care documentation system would enable this to be carried out. This was a concern to us as we had identified one person who had lost weight and this had not been recognised and therefore no action had been taken to improve the care of that person. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the care manager if other audits were carried out. We viewed a medication audit, which was completed in January 2015. We saw this had been actioned and the care manager told us this was being carried out by the manager of another home who was revisiting the home to ensure improvements had been made. In addition the care manager told us a new medicines system was being introduced in the next week to ensure medicines were administered safely. They said this was the result of the completed medicines audit which had identified improvements were required.

During the inspection we asked to see evidence of environmental audits and saw checks were carried out on emergency lighting, emergency fire call points and fire doors. We were provided with no other environmental checks.

The care manager told us they carried out an audit to capture the number and type of incidents that occurred in the home. We saw a document which listed the number of accidents, incidents and falls that had occurred in the home. We asked the care manager how they analysed the information to ensure trends were identified and lessons learnt to prevent reoccurrence. The care manager told us they reviewed accident forms but did not complete any analysis. They told us the qualified staff would tell them if a person fell repeatedly.

The lack of effective systems in place identify, assess and manage risks in relation to the health, safety and welfare of people and others who use the service meant people were not protected from the risk of harm. This was a breach of

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Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified shortfalls in the care documentation we viewed. From viewing the paper based care plans we could see that they were updated by writing entries on the original care plan. This was confusing and it was difficult to ascertain some people's current needs. We saw page one of a care plan, which showed a person required thickened fluids. It also contained an entry that indicated the person required a fortified soft diet; however this had been crossed out. Written on this page was a sentence, which said the person had been reassessed by a health professional and now required a normal diet and fluids. On page two of the care plan it stated the person needed a soft diet and thickened fluids. We were told by the qualified staff the person did not require this. The record was not an accurate reflection of the person's needs. Records should accurately describe the care and treatment a person requires to minimise the risk of inappropriate care and treatment being delivered.

A further person's care plan was written in May 2013 and contained instructions for the application of dressings; however there were entries on the care plan that showed there had been changes to the person's care. It was difficult to ascertain their current needs. This presented a risk of people who were unfamiliar with people's care delivering care and treatment that did not meet their needs.

We viewed another of the person's care plans and saw a handwritten entry that stated they required their fluids to be restricted. We questioned this with the qualified nurse and the care manager who told us the person no longer required this. The record was not an accurate reflection of their current needs.

We noted that two people within the home were receiving care, which was not included in their care plans. From viewing MAR records we saw one person required a cream to be applied and there was no care plan to inform staff of this. We also saw a further person had been prescribed eye drops. There was no care plan to inform staff of the care and treatment the person needed or how those needs should be met. The lack of detailed care plans for peoples identified needs meant that people were at risk of not receiving appropriate care. We concluded the records required improvement as the records should be accurate and up to date to minimise the risk of people receiving inappropriate care that does not meet their needs. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the care manager who explained a computerised documentation system was being introduced and all information from the paper based records was being transferred to the system. They told us they did check care records for accuracy of information and informed qualified staff if the records required updating. However they did not document the checks they carried out and were aware that qualified staff did not always make changes to the care plans.

We observed evidence of poor leadership and teamwork at Southwold Nursing Home. The care manager told us the home currently had apprentices in place. An apprentice is a person who is learning a skill from an employer. We asked the care manager to explain how apprentices worked with staff to ensure people received safe and effective care. The care manager told us they were assigned a competent member of staff to work with and did not deliver individual care. However on speaking to care staff we learnt they were unsure on the processes in place. The apprentices we spoke with were clear they would not deliver individual care however they were sometimes asked to do so from permanent members of staff We asked a member of staff to explain the responsibilities of apprentices and we were told "I don't know, the rules keep changing. They don't work alone though. Sometimes we're told they are counted in the staffing numbers and sometimes we're told they're not." Another staff member told us "The apprentices used to work in pairs with us but I don't know anymore. Sometimes they do sometimes they don't. Everything changes so quickly now." This demonstrated to us there was a lack of clarity of communication from the management at Southwold Care Home about expected practices affecting care. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the qualified staff to describe the leadership they received. Comments we received included; "I don't. I come and organise my shift because (the care manager) is lovely

Is the service well-led?

but what can they give me. They're not a nurse." We asked if they ever sought guidance from the care manager and were told; "No. What can they give me? They don't do my job so how can they know."

We asked one staff member to describe the leadership at the home. We were told; "It's awful. There's no teamwork here, no communication and everything is disorganised. It's alright for me, I can go home but the people who live here can't."

We asked the care manager how they provided direction and leadership to the staff at the home and were told; "I speak to them but if they don't do what I ask what can I do?" It is important that staff receive adequate leadership to ensure there is an effective oversight of the quality of care people receive and staff have clarity and direction regarding their role.

All the staff we spoke with told us they had not attended a staff meeting for many months. The care manager confirmed the last meeting had been in September 2014 and since then none had been held. They told us they were planning to hold a meeting to discuss areas such as staffing and documentation. Regular and productive staff meetings are important as they encourage teamwork, ensure essential information is cascaded and help increase morale.

Relatives we spoke with told us they found the care manager was approachable but also expressed concerns regarding the leadership of the home. Comments we received included; "It's chaotic here and a good manager would sort that." "The (care manager) is nice but I don't think that's needed here." And "Since the previous manager has left, things have gone downhill. I hope they sort it out." One relative described the care manager as, "One of the girls."

We asked the care manager if there was a business continuity plan to inform staff of the action to take if there was an emergency such as an outbreak of infection or major utilities failures. The care manager told us there was no plan in place as the previous plan had referred to the previous care provider and required updating. We asked what action staff were to take if such an event occurred. The care manager told us they could contact them for advice. Following the inspection we were informed the business continuity plan was being reviewed by senior management and staff had been instructed to contact the head office in the event of an emergency. However the lack of a business continuity plan at the time of the inspection, and the lack of staff knowledge of the arrangements in place, placed people at risk in the event of unforeseen events occurring. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the lack of leadership with the head of mental health and learning disabilities who told us the provider was actively recruiting a clinical lead who would also be the registered with the CQC as the registered manager. In addition we were told consideration was also being given to appoint a night manager to ensure leadership was provided during night hours. They told us the provider was committed to ensuring the home recruited the right person to ensure leadership was provided at Southwold Nursing Home. However our observations, the feedback from staff, relatives and the documentation we viewed evidenced that at the time of the inspection the home was not well led.

The owner of the home could not be present during the inspection. Following the inspection the owner contacted us as they wished to discuss the concerns we had identified. We spoke to the owner on the 10 of February 2015 by telephone to discuss our concerns. The owner of the home told us since the inspection they had appointed a quality assurance director who would be visiting and monitoring the home to identify shortfalls. We spoke with the quality assurance manager who confirmed they would be monitoring the home to ensure improvements were made.