Alphington Lodge Residential Home

Alphington Lodge Residential Home

Inspection report

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Alphington,
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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

We visited the home on 13, 21 and 23 January 2015. The visit was unannounced and was carried out by two inspectors. The service provides accommodation without nursing care and is registered for 28 people to live at the home.

There was a registered manager. 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.'

No-one living at the home was subject to a Deprivation of Liberty Safeguards (DoLS). However, during the inspection, the lead inspector identified several people who required an application based on information

Summary of findings

provided by the registered manager and senior staff. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes.

People living at the home were not protected against the risks of unsafe management of medicines. Risk assessments were poorly completed for people whose actions or care needs put them and/or others at risk. Staffing levels were inconsistent and therefore did not meet the required levels that had been assessed by the registered manager and providers to meet people's care needs. People living at the home were not protected against the risks of an unsafe building.

Poor auditing arrangements for people's finances and a lack of clear information for staff meant people were not protected from abuse. Improvements were needed to the home's recruitment procedure to ensure staff were suitable to work in a care home setting. Suitable arrangements were not in place to obtain, and act in accordance with, the consent of people living at the home. People living at the home were cared for by staff who had not been appropriately supported through training and supervision.

Staff practice did not always maintain people's dignity and privacy. Care planning did not people's individual needs and did not ensure the welfare and safety of people. There was not an effective complaints system to address people's concerns.

There was not an effective system to regularly monitor and assess the quality of the service and the risks to the people living there. The provider is required by law to notify the Commission of any allegation or instance of abuse. Notifiable incidents should have been reported and were not.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

People were positive about the quality and range of food at the home. They said the food was well cooked and they enjoyed their meals. People living at the home shared the following comments about staff "they feed me and look after me well" and another person said some staff were "extremely nice". Some visitors praised the quality of the care at the home but others raised concerns. They told us they felt these concerns were not always listened to by the registered manager.

Our findings do not provide us with any confidence in the provider's ability to bring about lasting compliance with the requirements of the regulations. We are taking further action in relation to this provider and will report on this when it is completed.

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 because people were not protected from the risks of unsafe management of medication. Risks to people's health and welfare were poorly managed. Staffing levels were not consistent and there was not a stable staff team. Some windows and the hot water temperature in one bathroom were unsafe. There were poor systems in place to manage people's personal allowances that made them vulnerable to abuse.

Inadequate

Is the service effective?
The service was not effective as staff had not been appropriately supported through training and supervision. Suitable arrangements were not in place to obtain people's consent. A lack of understanding of the Mental Capacity Act 2005 meant people who lacked capacity might not have their rights protected and may not be cared for appropriately.

Inadequate

Is the service caring?
The service was not always caring as some staff practice undermined people's privacy and dignity. However, there were also good interactions between people and staff, which showed some staff knew people well and could respond to them in a caring and reassuring manner. Generally, people looked well cared for and staff supported their friendships.

Requires Improvement

Is the service responsive?
The service was not responsive because the people's changing needs were not responded to appropriately. Lessons had not been learnt from a previous safeguarding alert and there was not an effective complaints system. Care planning was poorly managed. People's emotional well-being and welfare needs were not met.

Inadequate

Is the service well-led?
The service was not well led because on previous inspections where improvements had been made as a result of compliance actions or enforcement, these improvements had not been consistently maintained. This has negatively impacted on the lives of people living at Alphington Lodge. There have been nine inspections since 2011 which reflects the level of non-compliance. There have been recurrent concerns. This has demonstrated that the quality assurance system within the home was inadequate and did not protect people.

Inadequate

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Detailed findings

Background to this inspection

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

This inspection took place on 13, 21 and 23 January 2015 and the first two days of inspection were unannounced. Two inspectors were accompanied by an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone living with dementia who uses this type of care service.

Prior to the inspection we reviewed a range of information to ensure we were addressing potential areas of concern and to identify good practice. This included the Provider Information Record (PIR), which asks the provider to give some key information about the service, including what the service does well and improvements they plan to make. We also reviewed previous inspection reports and other information held by CQC, such as notifications. A notification is information about important events which the service is required to tell us about by law.

During the visit we met with people living at the home and 12 of these people shared their views on living at Alphington Lodge Residential Home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not comment directly on their experiences of living at the home.

We spoke with eight visitors at the home; a ninth visitor contacted us after the inspection. We also spoke with eleven staff including the registered manager; five staff members spoke to us in detail about their roles. We contacted the district nursing team, four other health professionals and the local commissioning and contracting team. We observed care and support in communal areas and visited people's bedrooms and two bathrooms. We reviewed a range of records about people's care and how the home was managed. These included the care plans for six people, the training overview for staff employed at the home, the recruitment files for three staff working at the home and medication records. We also discussed the quality assurance audits systems in place and walked around the home with a staff member.

Inadequate

Is the service safe?

Our findings

In October 2014, the Care Quality Commission was contacted by an anonymous person who raised concerns about the management and administration of medication in the home. This concern was passed to the providers to investigate. The outcome of their investigation resulted in disciplinary action and changes to the registered manager's medication auditing system.

The provider information return stated there had been 11 medication errors in the last 12 months. It gave details of how medication was managed within the home, including one senior member of staff taking charge of overseeing medication entering and leaving the service. The registered manager told us about this role. They advised because of staff illness and shifts having to be covered at short notice, protected time had not been given to a senior staff member to carry out this role effectively. The staff member confirmed this to be the case. On the first day of our inspection, the registered manager told us that medication which had been delivered to the home four days earlier had not yet been checked in. Staff said there had been a delay in providing one person with their prescribed medication; staff were unclear why there had been a delay. A staff member commented to us that the way information was shared in the home could be improved.

Medication was not managed safely. Medication records were not correct for people who were being supported by staff with their medication. For example, one person's medication blister pack had empty sections for three dates, which indicated the medicine had been given by staff, but medication records showed this medication as not being administered. Medication records for a different prescribed medicine were also inaccurate as the stock left did not match the amount recorded as administered. In the same person's room, we found half a tablet and a different colour tablet under their chair. This indicated staff had not ensured the person had taken their medication. The registered manager told us they were at risk of choking and needed liquid medication. This information did not match their prescribed medication some of which was in tablet form.

A bottle labelled paracetamol had been left on the person's sink and was accessible to the person and other people living at the home. Some people at the home were living with dementia and were put at risk by this practice. A new medication had been prescribed for the person but there was no record of the date on which it had been delivered to the service and no record of the amount. This meant there was not a clear audit of whether it had been administered correctly.

Medication records for a second person showed they had been prescribed a short course of pain relief medicine, which could be given in variable amounts. There was no information regarding the reason for the medicine and staff had not recorded how much medicine they had given, which could be either one or two tablets. This meant there was the potential for staff not to be consistent when the medicine was offered for pain relief or know how much was given. There was no record of the amount of medication received or the date it had been received. Or the month or the year it had been given.

There were 13 other examples of poor medication management, which included the application of prescribed creams not being recorded, secondary dispensing of medicines which is unsafe practice, unsafe storage arrangements, and poor audit trails relating to one controlled drug. During five previous inspections since 2011, medication was judged as non-compliant on three occasions.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people living at the home were not protected against the risks of unsafe management of medicines.

Risk assessments for individuals were poorly completed. For example, a health professional's care needs assessment for one person showed their mental health needs put them at risk of harm. This was known when the person moved to the home. However, the risk assessment did not provide written guidance to staff as to what action they should take to monitor the person's well-being. A staff member provided us with information about the steps they would take but this level of detail was not written in the person's care plan or daily records. Two months prior to the inspection, the person's mental health had declined and an incident had taken place. The risk assessment had not been reviewed or updated and a monthly care plan review of their 'emotional well-being' stated there was 'no change'.

The registered manager and staff told us the person's location was regularly monitored throughout the day to help reduce the risk. A tick chart was completed by staff as

Is the service safe?

part of this monitoring. Daily records did not show how the person's mental health was being monitored. Instead, they were task orientated. For example, the daily record for the day following the incident had one entry relating to what breakfast the person had eaten but no reference relating to the serious incident. We previously raised concerns about how this person's mental health was supported during an inspection in February 2014.

We highlighted our concern to the registered manager regarding how the risk of choking was managed. One person had been visited by a speech and language therapist because of this risk. The health professional had provided guidance about how food should be prepared for them to reduce the risk of choking. However, a list of dietary needs for staff to refer to had information that contradicted the written professional guidance which had been given. The registered manager and a senior staff member told us how this decision had been made, they checked paperwork but could not show us who they had consulted to make this change. The registered manager told us about a second person who had been assessed as at risk of choking. Daily records showed they had been administered medication by staff which was not in a liquid form and a tablet had become lodged in their throat. This was despite a risk assessment stating they must have liquid medicines.

There were other examples of poor risk management relating to skin care, monitoring people's weight and monitoring people's safety. In the provider information return, four people were identified as being at risk of malnutrition/ dehydration but the monitoring of food and fluid intake for people at risk was poorly managed. Risk assessments were stored in care plan files in the manager's office, which was in a separate building and were therefore not readily accessible to staff. Three staff said they did not have the time to access these files because of staff sickness levels, shifts running short and a number of people living at the home being unwell. Since 2011, poor management of risk to people's health and welfare has been highlighted in six previous inspections.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because risks assessments were poorly completed or not completed for people whose actions or care needs put them and/or others at risk.

The home's performance information record stated people at the home were kept safe by 'ensuring staffing levels are appropriate for the needs of our clients not the number of our clients.' In December 2014, we met with the providers and the registered manager to discuss steps taken to make improvement to the service.

During this meeting, the registered manager told us staff sickness levels had reduced as a result of a new two week rota and the use of two staffing agencies to help address staff vacancies, while recruitment took place. They said where possible the same agency staff provided cover. The providers told us the use of agency staff had reduced in the previous month, which meant people living at the home were cared for by permanent staff.

However, rotas for January 2015 showed there was a heavy reliance on agency staff and in one week there were 12 different agency staff working at the home. Four weekly rotas were not completed in a consistent manner and the registered manager's hours were not logged. This made it hard to judge who was working alongside the care staff team with the potential to provide additional support. We looked at the shifts for two weeks in January 2015 and saw there had been eight days when some shifts ran below the level advised by the providers.

A visitor told us their relative felt unsafe when they were moved by some agency staff because the staff did not know their relative well and did not provide the reassurance they needed. Permanent staff were generally positive about the skills and approach of the majority of the agency staff. A person living at the home said "staff are extremely busy" and reported they didn't know if they felt safe because they did not know the staff well and they did not introduce themselves.

One visitor told us there were enough staff but another visitor told us they were unhappy about the staffing levels on the previous weekend given the level of illness amongst the people living at the home and the number of people living at the home. After the inspection, the providers provided further information about the staffing levels for this period and this confirmed one morning shift had four staff rather than five because a staff member had rung in sick. There was also a high level of agency staff on duty over this particular weekend. A second visitor told us the staffing levels were always an issue and there was a lack of commitment by some staff to work their shifts at the weekends.

Inadequate

Is the service safe?

On the first day of our inspection, the registered manager and staff told us there had been high levels of staff sickness since Christmas. We looked at weekly rotas for a four week period. Two staff were off sick during one week, three staff were off sick during two of the weeks and one week there were five staff off sick. At the same time, staff and the registered manager reported high levels of illness amongst the people living at the home but additional staff had not been arranged to support people's changing needs.

During the first day of the inspection, call bells were ringing constantly throughout the day. At one point two staff members were writing records, while a call bell kept ringing. A senior named two staff who they said were working in the area of the person's bedroom. However, one of the named staff members had gone on their break and the other had been asked by a senior to accompany the community nurse to someone who was unwell.

The bell kept ringing; eventually they confirmed they would check on the person. During a handover on the same day, a call bell kept ringing. Staff attending the handover did not respond or make reference to it until a new staff member on their induction asked if they should respond, which the senior agreed should happen.

People told us about the impact of staffing arrangements on them. People had different experiences but all expressed concerns about low staffing levels. They told us "There's not enough staff at night...I ring the bell and they don't come" while another person said "They're occasionally short staffed but they usually come quickly...at night they come in to check me very couple of hours...the night staff are excellent". A third person said "They're short staffed all the time...I ring the bell for the commode but have accidents...this morning I was ringing for about an hour". A fourth person told us "I ring and ring and ring and nobody comes". They told us the delays resulted in episodes of incontinence, which they also told us during an inspection in 2014. A fifth person said "Sometimes they come quickly and sometimes they take a while". A sixth person told us they had a similar experience.

Staff and one person commented that further delays could take place in providing support with personal care if the person needed two staff members to help them move. The registered manager told us during feedback that they were changing how staff covered different areas of the home.

They recognised one person may have experienced incontinence issues because staff were not regularly monitoring the part of the home they spent time in and therefore could not support them to find the toilet.

Three visitors told us the staff were always busy; one person commented that the staff were "run off their feet". The minutes from a relatives' meeting in September 2014 recorded concerns over the staff turnover and shifts running under the planned level; the registered manager advised some people had left for positive reasons such as career development.

A staff member commented to us that it was "the busiest home I've ever worked in" and another said that there was "too much pressure on staff". A third commented that staff could not be retained because in their view there were high sickness levels and this placed pressure on other staff. A fourth stated they would not move their relative to the home because there were not enough skilled staff. Staff told us staffing levels were not at an appropriate level and several believed an extra staff member in the morning would help meet people's personal care needs. A staff member told us staffing levels could impact on whether people were offered baths and showers. However, because of several people being admitted to hospital, they said on their shift, staff had managed to provide this support because there were less people to care for. On the same day, a person told us they were waiting for a shower and later we saw them as they were returning to their room after this had taken place.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were not sufficient numbers of suitably qualified, skilled and experienced people.

Audits stated the safety of windows in the home had been checked; in December 2014 it was recorded that they were 'safe'. However, when we checked the sash window in a first floor bedroom there were no restraints fitted and it was not difficult to open. This was also the case with a bathroom window. After prompting from us, a staff member agreed to check a further eight windows which they had identified as being unrestricted. Work to rectify this began during the inspection.

An audit showed the water temperature from bath taps was monitored on a monthly basis from the temperatures recorded by staff when they gave people a bath. These

Is the service safe?

records showed that recently the temperature was within the recommended scale. However, this did not cover the temperature of the hot water from a sink in one of the bathrooms, which scalded an inspector's hand and exceeded the temperature scale on the thermometer kept in the room. The registered manager told us this sink was not used regularly as people in the rooms nearby either had their own sink or would not use this bathroom. They said this therefore did not pose a risk to them. We advised there was still a risk to people visiting the home or other people living at the home.

The home's performance information record stated 'all residents have a P.E.E.P.s in case of evacuation.' This referred to personal emergency evacuation plans. There was a file in the hall near the front door which contained people's personal evacuation plans in case of a fire. The information was out of date and there were two plans for people who no longer lived at the home.

There were no plans for two people who were now living at the home. This meant the fire evacuation system was not effective and had the potential to cause confusion when guiding staff to how people should be evacuated or supported in the event of a fire. Fire training records showed the majority of staff were up to date or had been due an update in December 2014. However, a member of the night staff had no record of training. Agency staff starting their first shift at the home were shown the fire exits. Two staff told us the evacuation plans were kept in the office in people's individual care plans, which they commented would be difficult to find in an emergency; they did not refer to the folder in the hallway. A new member of staff did not know where the plans were kept.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people living at the home were not protected from the risks associated with an unsafe building.

Four staff told us about their duty to report abuse in a timely manner either to a senior, the registered manager or the providers. Some people needed to be reminded to ensure the person felt safe before they took this action. Staff said the registered manager was always available to them to give advice. A safeguarding procedure and contact numbers for an external safeguarding agency were displayed on the registered manager's office wall but care staff did not have this information readily available to them. Staff knew they could contact an external agency but for two people this was based on safeguarding training from previous jobs.

Incident and accident records for the last 12 months were checked; there was an incident regarding self-harm which had not been reported by the registered manager to the local safeguarding team. Records kept by the registered manager regarding concerns for two people had not been reported to safeguarding despite being linked to missing money and a person's well-being. They told us they had reported one incident retrospectively but they had not sought appropriate advice at the time of the concern. The registered manager told us two weeks later the missing money appeared to now be accounted for; an alert should have been made at the time of the alleged theft.

Records for six people who had personal allowances managed by the registered manager were poorly kept. Credits and debits were not routinely signed by two staff members, some debits were not signed at all and sometimes the reason for the debit was not recorded. People were not routinely asked to sign the records themselves, which indicated they may not have had the capacity to manage their own money but this had not been assessed. The money in one account was less than recorded on the record sheet; the registered manager checked through the receipts with us but the deficit of £18.90 could not be resolved. On the third day of the inspection, the filing cabinet containing the personal allowances was left unlocked in an unlocked and unsupervised office.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people living at the home had not been safeguarded against the risk of abuse.

The registered manager told us they were actively recruiting for seniors and care workers and updated us on forthcoming interviews and the quality of recent applicants. Three recently recruited staff members all had previous experience in care. All files showed staff had been checked against the Disclosure and Barring Scheme before they began working with people living at the home. These checks identify if prospective staff had a criminal record or were barred from working with vulnerable people. Newly recruited staff had produced relevant identification documents and two had completed application forms.

Inadequate

Is the service safe?

References were in place but improvements were needed relating to one recruitment to ensure they were from the most appropriate person at their previous employment.

Two references taken over the phone by the registered manager were not dated, which meant there was a not a clear audit trail of decision making regarding the staff members' suitability.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act (2005) (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Records showed some staff had completed safeguarding training; discussions with staff showed they were unclear if this included awareness of the MCA. They told us at a recent staff meeting they had been provided with a print out with some information on this subject but were unclear if they had received training in this area. Staff identified some people living at the home as not having the mental capacity to make some decisions relating to their care.

The registered manager told us mental capacity assessments had not been completed for anyone living at the home. There were examples of no records of best interest meetings taking place to help protect the identified people's rights and how decisions were made. The registered manager discussed the risks to the well-being of some people. This discussion showed there was a lack of clarity as to whether people's mental capacity had been considered for some of the decisions taken relating to their care. The service's performance information record stated training in this area of care would be booked and completed by the end of June 2015. After the inspection, the registered manager sent confirmation of her practioner's training to take place in February 2015.

In December 2014 we met with the providers and registered manager, we advised that the next inspection would include looking at how practice at the home demonstrated an understanding of the MCA and Deprivation of Liberties Safeguards (DoLS). DoLs provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. The service's provider information record stated there was no one living at the home subject to authorisation under DoLS. The registered manager confirmed no applications under DoLS had been made. Our observations, discussions with staff and people's care records showed applications should have been made for at least four people living at the home. Health professionals have since advised the providers that applications must be made.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because suitable arrangements were not in place to obtain, and act in accordance with, the consent of people living at the home.

The registered manager told us people living at the home were well-supported by the local GP surgery and the weekly visits from one GP. There was positive feedback from a health professional regarding the timeliness of referrals to the surgery; they had no concerns regarding the care at the home. They commented that a number of people living at the home had complex care needs which put pressure on the staff.

A visitor expressed concern that there was not a clear plan as to who should be referred to see a GP. This was based on an incident when their relative had been unwell. In their view, staff needed prompting to recognise the person's health was deteriorating and contact a health professional. The person was admitted to hospital.

Staff discussed who should be referred to see the GP during their weekly visit; staff did not review care records and their decisions were based on information from that morning rather than an overview of everyone's health and well-being since the GP had last visited. The registered manager told us there had been occasions when referrals to the GP had been unnecessary as the problem had been resolved because some staff were not up to date to changes in people's health.

The service's provider information record did not provide details of staff supervision arrangements or how training was managed. The registered manager told us an induction and on-going training was provided by an external agency; they provided us with a training matrix from this agency of current training records. It was not up to date as three established members of staff were not on the matrix and nine people were no longer working at the home. Training had been identified for an area of development in a previous inspection in 2013.

Moving and handling training was recorded and an e-mail from the registered manager confirmed an update for ten staff had been booked after the second day of inspection. We were told new staff members' practice was observed by a staff trained in moving and handling practice as part of their induction. A staff member said this had not happened before they began moving people with equipment.

Inadequate

Is the service effective?

Three staff involved in medication administration had no training logged, which reflected the poor medication practice found during this inspection. The registered manager advised us in an e-mail after the inspection that training had been arranged for senior staff. This did not include a member of the night staff who administered medication.

Infection control training was not up to date for the majority of the staff and an e-mail from the registered manager confirmed an update for 16 staff had been booked after the second day of inspection. A staff member advised they had been given no instructions about emptying commodes and how they should be cleaned.

Staff said some people they cared for were living with dementia but they had not received training or updates in this area of care, which was confirmed by training records. Discussion with a staff member regarding a reality orientation approach confirmed their knowledge needed updating, which they had identified as a training need.

Staff said they did not routinely have supervision sessions to discuss their performance and training needs; this was confirmed by supervision records. Staff meetings can be used to supplement supervision sessions. We asked for the minutes of these meetings since the last inspection; these meetings did not occur regularly. For example, there had been two general staff meetings in six months. The registered manager gave us a copy of the staff handbook which was provided to new staff but two new staff said they had not been given a copy. One staff member had been asked to read a training manual for an overview of care practice; it was 13 years old and the information may not have been based on current practice. People living at the home did not raise concerns about the way staff supported them with their care. Four visitors said they had no concerns regarding staff skills.

Two staff expressed frustration about how the home was run but one said despite this concern they felt "massively valued". Another staff member said they felt well supported by the registered manager.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people living at the home were cared for by staff who had not been appropriately supported through training and supervision.

The service's provider information record stated there was a choice relating to food and drink. During the inspection, the cook spoke with people about their preferences and took time to listen to people's opinions. Our conversation with them reassured us. They knew the people living at the home and their likes and dislikes. People were positive about the quality and range of food at the home. For example, a person told us they did not like pork. This was recorded on a dietary information sheet for staff and the person was provided with an alternative to pork for their lunchtime meal. Another person had become concerned about their swallowing and they were provided with a meal prepared in a style to reduce their anxiety. At one of the lunchtime meals during our inspection, a third person was reluctant to eat and staff tried to tempt them with alternative meals, which linked to their preferences.

Staff ensured people knew there was a choice of main meal, menus were also available in the dining room and the food was well presented. People said the food was well cooked and they enjoyed their meals. People said they could choose where they ate their meal as some people said they preferred to eat alone; staff respected their wishes. During the inspection, a visitor who had joined their relative for lunch told us it was "superb lunch". Written feedback from a person who had stayed at the home for respite stated the "food was fantastic."

Requires Improvement

Is the service caring?

Our findings

People's confidentiality was not always respected by staff. For example, in a communal area a staff member said to another in front of the person they were talking about "Can you just give me a hand so I can do her bottom?" And on another occasion several staff spoke about the last hours of a person who had died at the home while supporting another person, who was not part of the conversation. There were a number of other examples where people's dignity was undermined because staff did not consider how and when they shared information with each other. A health professional expressed concern to us regarding a comment made by the registered manager whilst they visited, which they felt undermined people's dignity. This meant newer staff did not have strong role models to promote confidentiality and respect people's privacy.

The service's provider information record stated staff had training in dignity and respect, although this was not recorded on the training matrix, which was sent to us. A person was moved using equipment in a communal area without staff considering their dignity; people's incontinence pads were left on display in their room. This type of poor practice was highlighted at a previous inspection in 2013.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the registered person had not made suitable arrangements to ensure the dignity and privacy of people was respected.

The home provided end of life care for people but the training matrix did not record if staff received training in this area of care. A staff member told us they were not asked about their experience in interview and relied on their training from a previous job. They felt staff would benefit from more support in this area of care to ensure people's dignity was respected after death. Feedback from a visitor whose relative died at the home praised the staff's compassion and care during this period. A staff member was provided with an award for their professionalism and sensitivity when providing end of life care to another person. Other visitors praised the staff for how they supported them when their relative was dying and how they made the person 'more comfortable'.

People living at the home generally spoke highly of the staff and their approach. For example, one person said "I couldn't wish for better...the staff do everything that's necessary...all I have to do is say thank you...hard as I look I can't find anything to complain about...I looked at places and chose this one and I was right...they feed me and look after me well." Another person said some staff "were extremely nice" and carry out a "fair job" but other staff could be rude, which they challenged. They gave the example of a staff member telling them they had been given breakfast when they hadn't; the staff member later brought them breakfast after checking with other staff but had not initially listened to the person living at the home. A relative mentioned that sometimes staff chatted together rather than speaking with people living at the home. A person in the large lounge commented to another person "I don't understand that we're here...but she's talking with someone in the kitchen". The staff member was talking with other staff.

Some staff asked for people's consent before providing support to people. Some staff checked with people about what they wanted to happen. But records did not routinely show that staff were asking for people's consent before supporting them with their care needs.

A number of people told us companionship was important to them. For example, people said "I've got some good friends here" and "I'm not a loner and have made friends". Two other people had become close friends and arrangements were made for them to eat their meals together. Staff supported these friendships and generally respected them, although at times confidentiality was breached when discussing them. Staff were also aware when some people living at the home did not have a good or safe relationship and they ensured they were seated away from one another.

People looked well cared for, including their clothes. A visitor commented there had been significant improvements since the employment of a staff member who oversaw the management of the laundry. This was confirmed by a person living at the home, who said "the laundry's good...things have gone missing but I tell X (staff member) and she'll find them for me."

During our inspection, staff were cheerful and friendly towards the people they cared for despite on the first day being extremely busy due to high levels of sickness amongst the people living at the home. Staff listened to

Requires Improvement

Is the service caring?

people while they supported them with a task, although they had little time to sit down with people for a chat. For example, in the lounge a person was only spoken to briefly by staff in a period of an hour. The conversation related to their choice of drink and to be informed that staff were going to move them using equipment. There was no meaningful conversation that supported their well-being. The only stimulation was the television, which had sub-titles and no volume, they did not watch it.

Feedback from a person who stayed for a short time at the home included the comments that staff were "kind, helpful, caring and understanding" and a visitor wrote the staff to say their relative was "very happy with you." Five people living at the home told us about their relationship with the registered manager, which they described in a positive manner. Two visitors told us "I have faith in everyone" and another described all the staff as "lovely" but a third visitor said staff did not always talk to their relative when they assist them to move. They asked us if this was too much to expect; we agreed this was not good practice.

People using the dining room at lunchtime were supported by staff who were attentive and caring in their approach. And at times, we saw staff speaking gently and sensitively to people. Minutes from a relatives' meeting in September 2014 recorded that the registered manager paid tribute to staff saying that 'when there are trips/fetes etc. the staff will come in unpaid so as to assist with the residents...staff team work really hard often doing over and above what is expected of them and she will support them 100%.'

Some bedrooms in the home had been personalised; people told us they could bring in their own furniture and told us this gave them comfort. Many of the rooms were well decorated. There was a vacant room that smelt unpleasant but other rooms smelt and looked clean. People told us they were satisfied with the standard of cleaning.

Inadequate

Is the service responsive?

Our findings

In September 2014, a safeguarding alert was made by a health professional regarding the management of a person's skin care, who had been assessed as being at risk of pressure sores. Charts were put in place to record when the person was re-positioned to alleviate this risk; charts were poorly completed and did not demonstrate practice had changed. Two night staff had recorded in the person's daily records that there was a red area on the person's skin but there was no written evidence this concern had been monitored as a result of this concern. The person's care plan said 'vulnerable to sores'.

Staff checked the person's skin and told us the redness had been caused by moving and handling equipment rather than pressure damage. The person's relative confirmed the person experienced pain when they were moved. Despite this being a concern, there was no moving and handling plan in their room. A health professional voiced concern to us that lessons were not learnt at the home. This type of poor response to risks was previously been highlighted as an area for improvement during an inspection in 2013.

Daily records did not evidence how people's well-being was supported, instead they were more task orientated, and connected to personal care. For example, the care records for one person showed they were in pain and uncomfortable but records for 30 days did not evidence how they were reassured or that their discomfort was understood by staff. Most entries were brief and task orientated. One entry suggested a lack of understanding by the staff member about the person's experience as they described them as 'lazy' and needing 'pushing to move'.

We have other examples where people's changing needs were not responded to and monitored appropriately. Reviews of people's emotional and physical health were poorly completed. However, some relatives commented that people's health needs were monitored by staff and health professionals contacted appropriately.

Moving and handling plans were kept in care plans in the manager's office; the registered manager said it was kept locked when it was not occupied. They said senior care workers had the code to access the room but this would not be shared with other care staff. We queried with care staff how they accessed these records. They told us they did not read them because they did not have time to go across to the office. This meant potentially people might be moved incorrectly and not moved in a safe and consistent manner. After a discussion, the registered manager decided to move the information back into people's rooms to provide guidance for staff.

New staff were not provided with an overview of people's care needs; during a handover a staff member had to prompt colleagues for basic information, such as people's room numbers. The registered manager said they had meant to give new staff a list of people's names and their room numbers. New staff told us about their knowledge of people's individual needs and potential risks; they had not been informed that one person could become violent towards staff. The registered manager told us this was a new behaviour for the person but care staff said this was not the case, which an incident record from October 2014 confirmed.

The registered manager and care staff said there had been high levels of staff sickness in December 2014 and January 2015 resulting on a reliance on agency staff for most days in late December 2014 and early January 2015. They told us no printed overview of people's care needs was available for agency staff despite some being new to the service. A new agency person on their first shift was not told about a person's specific communication needs and was asked to attend to them.

The registered manager told us pre-admission assessments took place before people moved to the home and that people were encouraged to look around. Records for one person who had recently moved to the home showed there was contradictory assessments and advice regarding the use of equipment to move them. The registered manager also acknowledged their room was too small for larger moving and handling equipment. This was despite the initial information on their assessment regarding the use of a stand-aid. This has previously been highlighted as an area for improvement during an inspection in 2013.

The selection of care plans we looked at had been signed by individuals living at the home. One person told us "I know about my care plan and it was pretty thorough". In response to an inspection in 2014, an 'At a Glance' overview of people's care had been created to be kept in people's rooms, as people's main care plans were kept in the registered manager's office. However, when we checked

Is the service responsive?

people's care files in their rooms these were not regularly in place, which staff confirmed. The registered manager told us they thought these may have been mistakenly removed when daily records were archived.

Staff told us they did not have time to stop and speak with people instead conversations were based around care tasks. Some relatives also expressed this concern. People told us about how they passed the time. One person said "I do very little...we just sit in these chairs after meals...sometimes someone comes with a bag of plastic balls and skittles...it's so childish". Their care plan stated that their mood became low if they were left with no activities to do. Another person said they passed the time "dozing" in their room; a third person told us they enjoyed helping fold the laundry. Two exercise to music sessions took place during the inspection, which a small group of people participated in. Some people told us about a trip to the cathedral before Christmas and a visit from a school choir, which they said were enjoyable. Information for activities still related to Christmas so was three weeks out of date.

Staff sickness had impacted on running an activities programme in late December and January but the registered manager acknowledged that when it was running the activities person still found it hard to meet everyone's individual interests. She hoped the hours allocated to this role would be increased. Some people spent time in their rooms dozing or watching television; some people in communal areas chatted to each other while others seemed isolated. A person told us it was hard to make new friends and staff didn't have time to introduce them to other people living at the home. Staff said that records of activities would be in people's files in their rooms but we could not find these records.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because care planning did not meet people's individual needs and did not ensure the welfare and safety of people.

Health professionals provided us with a range of feedback about how the service supported people with their health needs. One health professional commented they gave written instructions to reduce risks to people's health but records were poorly completed by staff, and it was therefore unclear if advice relating to people's skin care and positioning had been followed. They raised a concern that staff did not appreciate the importance of the correct use of prescribed hosiery. They commented there was a lack of organisation within the home, for example there was a delay in a blood test for a person after a hospital appointment because the paperwork from the hospital had been mislaid.

Two health professionals were consulted during the inspection about our observations and our concerns; they confirmed based on our information that advice and guidance was not being followed relating to advice for food preparation and the management of catheters. Concerns from health professionals regarding poor communication within the home have been recorded in previous CQC reports.

The provider information record stated 'we have a robust complaints procedure...' and that there had been eight written complaints which had been managed under the home's formal complaint procedure. We were given a copy of 'Guidance on How to Make a Complaint'. It was out of date as a staff member named on the sheet had left the home approximately six months before the inspection.

The registered manager told us they tried to promote "transparency" when dealing with complaints They described a meeting with a relative to help re-build their trust but were unable to find the minutes from this meeting. The registered manager talked to us about the concerns and complaints that had been made since the last inspection in July 2014. There was a poor management of records as the registered manager did not have all the information collated in one place; this made it difficult to assess. For example, there was a letter responding to a relative about a complaint linked to poor communication by staff but no log of the original concern.

The registered manager included staff complaints in with the information she shared with us. The paperwork for one incident relating to an alleged medication error showed it had been poorly investigated with no recorded outcome.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there was not an effective complaints system to address people's concerns.

People were generally not critical about the service at the home and found it hard to suggest ways it could be improved. They could not give examples of things that had changed as a result of suggestions or meetings, although people were asked about the menu and could influence

Inadequate

Is the service responsive?

the food that was served. Two people said they were confident they could speak to the registered manager about concerns but said they had no current concerns. A third person said they could speak with the registered manager if they had a complaint but they were not confident how often they would see her to pass on any concerns. In contrast, a fourth person said "I see X regularly...she's a good manager...she really tries."

Inadequate

Is the service well-led?

Our findings

The service not well led because on previous inspections where improvements had been made as a result of compliance actions or enforcement, these improvements have not been consistently sustained.

The manager was registered with CQC in December 2013. There have been five inspections since then and at every inspection there was one area or more of the service judged as non-compliant. The impact of non-compliance was judged as ranging from a minor to major impact on people living at the home.

Two providers own the home as a partnership. Since 2011, CQC have inspected the service nine times. Only one of these nine inspections was judged as being fully compliant in all the outcome areas that were inspected. The impact of non-compliance on people living at the home was judged from moderate to major impact on five of these inspections.

Since 2011, CQC has been contacted by whistle-blowers, visiting health and social care professionals and safeguarding professionals with concerns regarding the standard of care and staffing at the home. The number of inspections reflects the level of non-compliance and recurrent concerns.

CQC has met with the registered manager and the providers to discuss the level of on-compliance and concerns. Our most recent meeting was in December 2014, when we discussed the latest action plan to improve the service and how the quality of the service was monitored. The outcome of this inspection demonstrated that quality assurance systems in the home were not effective.

Visitors to the home gave us mixed feedback about the effectiveness of the registered manager to respond to suggestions and concerns. Their views differed on how the service was run, one said “There are no problems at all...if I thought there were, believe me I’d report it” and another visitor said problems were resolved quickly once they were identified.A third visitor told us they had made a verbal complaint about staffing levels to the registered manager; we had asked the registered manager to share all recent complaints with us but we were not told about this complaint. And there was no record of this complaint.

Two visitors expressed frustration at the length of time taken to address concerns and gave us specific examples. One told us in their opinion the registered manager “palmed them off” and did not take their concerns seriously because they were not confrontational in their style of complaint. Minutes from a relatives’ meeting in September 2014 identified areas of dissatisfaction regarding delays to complete work to the environment; a staff member commented ‘it would be nice if staff and relatives could work together as a ‘family’ and not against each as we all have the same goal, to do what is best for our residents’.Based on the content of the minutes, at times the tone of the meeting was confrontational. There was no action plan as a result of this meeting; this issue was highlighted on a previous inspection in 2013. The minutes record that the registered manager said she was ‘working really hard to get to the bottom of the problems here and asked for the support of the relatives’. Based on written records and a lack of clarity by the registered manager about the reasons for some of their decisions we judged that complaints were poorly managed.

The registered manager told us they had delegated some tasks to other staff members including writing care plans, reviewing care plans and training arrangements. We expressed our concern that the standard of some of care planning was poor and had been inadequately reviewed. We saw e-mails between the training provider and the registered manager which indicated a lack of clarity over training arrangements. After requesting the training matrix, training was arranged in a reactive manner by the registered manager rather than as part of a planned training programme.

The registered manager said sometimes they had been too trusting and had not questioned the arrangements within the home enough. They had not quality assured audits completed by another staff member, which we quickly identified as being poorly completed by spot checking the information. However, there were also audits and work practices which they had been involved in that were not well managed, for example medication, recruitment and personal allowances.

Auditing systems did not demonstrate how identified areas for improvement were addressed by the registered manager. During the inspection, particularly on the first day of the inspection when a number of people were unwell, the call bells were constantly ringing. The registered

Is the service well-led?

manager told us the system could not be audited as there was no call bell history to show how long it took staff to answer a call. Staff told us the call bell system did not enable them to judge who called first when there were several numbers showing. Seniors told us they had devised a way of addressing that the system did not indicate when two staff members were needed. But a new staff member was not aware of this arrangement.

The registered manager told us she was arranging for a quote to replace the call bell system. In 2013, the registered manager told us during an inspection they were considering improvements to the call bell system to make it safer and more efficient. A relative expressed concern that in the main lounge only one person had access to a call bell and there were times when it was hard to find a staff member. We observed this to be the case. The registered manager told us this area was regularly monitored by staff, which they felt addressed this concern. However, after the inspection, they told us they had now made the decision to base senior staff in this area to monitor it. A visitor told us "nobody wants to make decisions" and a staff member said "nothing gets done quickly." We have other examples of delays addressing areas for improvement.

Auditing systems did not demonstrate how identified areas for improvement were addressed by the providers. For example, a monthly audit completed by the providers in October 2014 recorded that two staff felt unsupported by seniors. The registered manager provided us with the minutes from a staff meeting in December 2014; there was reference to care staff still feeling unsupported by seniors.

During this inspection in January 2015, staff told us they remained unsupported by some senior staff because they did not always provide hands-on care. Another staff member commented that this had a particular impact when two seniors worked a shift; we observed this during our inspection. The staff member said they had informed the registered manager that these shift patterns did not work but the registered manager had delegated the rotas to another staff member and the practice still went on. The action from the provider's audit in October 2014 was for the registered manager to address this issue but there was no follow-up action by the providers to ensure it had been addressed. We have other examples of poor monitoring of areas for improvement.

A staff member expressed concern about the lack of planning regarding the maintenance of the building. They also told us bedrooms were not routinely decorated when they became vacant; some paintwork was marked and needed repair in corridors. A staff member said "there is no plan" and told us they felt ashamed when people visited to look around. We visited a person's bedroom, there was no lampshade, the cushion on the armchair did not fit or match it and the bedside table was scratched and marked. A visitor told us they had been promised a new carpet when their relative moved to the room but this had never happened. There were references to maintenance in the providers' monthly assurance reports but there was little detail. We have other examples linked to the auditing of the building with regard to call bells and first aid equipment which showed the standard of quality assurance was poor.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there was not an effective system to regularly monitor and assess the quality of the service and the risks to people living at the home.

The annexe of the home without heating during the first day of inspection. Two people lived in the annexe; additional heaters had been placed in their rooms, which had been switched on prior to people returning to the rooms in the evening. The registered manager confirmed there had been no heating for several days as a new part was on order but they had forgotten to notify CQC of an event which interrupted the service. They did this retrospectively. We saw from previous inspection reports and from providers' monthly assurance reports that there had been problems with the heating on previous occasions. By the second day of the inspection, the heating was working again in this part of the home. A relative told us they had been kept informed about the work.

The service's PIR which recorded one person had died at the home in 2014. Based on the records we saw in the home, we queried with the registered manager whether this was correct. During the inspection, she was unable to find the information we requested but afterwards she told us two other people had died at the home. Later the providers sent us further information which showed the information from the registered manager was incorrect.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Inadequate

Is the service well-led?

because CQC had not been notified of incidents within the service relating to people who have died at the home and when the heating supply had been interrupted for a period over 24 hours.