Caspia Care Limited

Elliscombe House

Inspection report

Higher Holton
Wincanton
BA9 8EA
Tel: 01963 33370
Website: www.caspiacare.co.uk

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Ratings

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

Overall summary

Elliscombe House is registered to accommodate up to 40 people. The home provides personal care and nursing care for older people, some of whom may be living with dementia. Accommodation is arranged over two floors, although the first floor is not currently being used. It is an Edwardian country house which has been adapted to meet people's needs. There were 21 people living at the home at the time of our inspection.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The home was being managed by a temporary manager as the new permanent manager resigned and left employment on the 16th August 2015.

This inspection took place on 3 and 7 August 2015 and was unannounced.

People said the home was a safe place for them to live. However, people's medicines were not well managed to

Summary of findings

ensure people received them safely or effectively. There were not enough staff to ensure people received safe and effective care. Accidents and incidents were not always followed up to prevent a recurrence.

Although people and their visitors made some positive comments about the care provided by staff, we saw that people often had to wait for care to be carried out. Staff were very calm, caring and dedicated despite working in challenging circumstances due to staffing numbers and a shortage of permanent staff. One relative said "They simply don't have enough staff. Some of the agency staff are brilliant but others don't know people here."

People were not involved in planning and reviewing their care. Some people's care plans did not accurately reflect their care needs. When people were unable to make all of their own decisions they could not be assured that care and treatment was always provided with the consent of a relevant person.

Staff did not always respond appropriately to people's changing needs. People did not always have enough to eat or drink. Mealtimes needed better organisation.

Permanent staff had good knowledge of people, although staff practice was inconsistent. There was a lack of consistent staffing and high use of temporary agency staff. Staff were supervised but not well trained.

People's privacy was respected. Staff ensured people kept in touch with family and friends. The choice of activities and opportunities for people to go out were limited. There were very limited opportunities for staff to spend quality time with people.

People saw appropriate health and social care professionals to ensure they received treatment and support for their specific needs. One person said "I do see my doctor if I'm not well. They always make sure of that."

There were quality assurance systems in place; these were not effective. The management, leadership and staffing of the home had been inconsistent. There was a lack of leadership 'on the floor' where care was being delivered. Some key information given to us by the provider before the inspection was found to be inaccurate.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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.

People's medicines were not well managed to ensure people received them safely or effectively.

People were protected from abuse. Risks were identified but not always managed well.

There were insufficient numbers of staff to keep people safe. Staff recruitment was well managed.

Requires improvement

Is the service effective?
The service was not effective.

People did not always have enough to eat or drink. Mealtimes needed better organisation.

People and those close to them were not involved in their care. People could not be assured that care and treatment was always provided with the consent of a relevant person.

People saw health and social care professionals when they needed to.

Staff received supervision but on-going training was not being provided to make sure they had the skills and knowledge to provide care for people.

Inadequate

Is the service caring?
The service was caring.

Staff were kind and considerate, although care was often based around completing tasks. There appeared limited opportunities for staff to spend quality time with people.

People were supported to keep in touch with their friends and relations.

Requires improvement

Is the service responsive?
The service was not responsive.

Some people's care was not planned and delivered in line with their current or changing needs.

People shared their views on the service. People's views and experiences were not always used to improve the service.

People chose how to spend their day. There were limited activities and no planned trips out of the home.

There was a complaints procedure in place. People were confident that complaints would be taken seriously and investigated.

Inadequate

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

The service was not providing consistently high quality care.

There was a lack of consistent management and leadership of the service.

The systems in place designed to monitor the quality of the service and its compliance with the law were not effective.

Elliscombe House

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 7 August 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, one specialist professional advisor in nursing care for older people and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection we spoke with nine people who lived in the home, 10 visitors, two registered nurses, six care staff, the activity coordinator, the home's manager (who subsequently ceased their employment on 10 August 2015), the previous manager and the provider's regional manager who oversees a small group of homes. We observed care and support in communal areas, spoke with some people in private and looked at the care records for eleven people. We also looked at records that related to how the home was managed, such as audits designed to monitor safety and the quality of care.

Before our inspection we reviewed all of the information we held about the home, including the provider's action plan following the last inspection and notifications of incidents that the provider had sent us. We looked at the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Requires improvement

Is the service safe?

Our findings

When we last inspected this service in September 2014 we found that at times there were not enough qualified, skilled and experienced staff to meet people's needs. We also found that people were not always protected from abuse as staff had not always raised safeguarding alerts to the local authority or responded to concerns about people's safety. Following the inspection the provider sent us an action plan which set out the improvements they intended to make. These would be completed by 30 November 2014.

Although people felt the home was a reasonably safe place for them to live, one person told us "I feel safe here", we found people were not always supported by sufficient numbers of suitable staff to keep people safe and consistently meet their needs. On both days of the inspection we observed reasonably long periods where there were no staff in the main lounge despite people using this room. On the first day of our inspection one person tried to transfer themselves from a dining chair to their wheelchair. The nurse administering medication had to stop this and rushed over to assist the person to prevent them falling. One relative said their family member "Had fallen at least six times after undoing (the lap strap) used to support her but that also held her in the wheelchair."

Staffing numbers were determined by the use of a dependency tool which assessed people's care needs. However, as occupancy levels had increased in the home, staffing levels had remained the same. One person said "I don't really like the agency staff. I prefer the usual girls; I like them and trust them." Comments from relatives included "Today there are good staff I shall go home not worrying, but it's not always so", "I want to know [my family member] is safe and well cared for if I can't be there and sometimes I am not sure" and "They simply don't have enough staff. Some of the agency staff are brilliant but others don't know people here."

The PIR stated 10 staff had left employment in the last 12 months. Although the provider had been trying to recruit new staff to fill these vacancies, this had not been successful. There were vacancies for two registered nurses (out of a team of five) and vacancies for five care assistants (out of a team of 17). There was high use of agency staff to cover staff vacancies. Staff rotas confirmed agency staff worked in the home every day; sometimes there were only agency staff on duty, although this was rare. The provider tried to ensure consistency of agency staff although this was not always possible. This meant that people were sometimes cared for by staff who did not know them.

Each member of staff spoken with said they did not feel there were enough staff on duty to meet people's needs and keep them safe all of the time. One staff member said "People's needs are very high here; they really depend on staff for everything including keeping them safe. We don't have enough staff; they really need to look at the staffing levels." Another staff member told us "I have been doing many extra shifts recently due to the shortage of staff because the residents would not get the care they needed as there are no staff to work in the home."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff usually gave them their medicines, although people could look after their own medicines if they wished to. Nurses gave most medicines to people. Medicine administration records showed that medicines were signed for when received from the pharmacy and when they were administered or refused. Care staff administered 'topical medication' such as creams or ointments. The nurse did not sign people's records to confirm these had been administered; care staff were responsible for recording this. We found recording of topical medicines were inconsistent. This did not give a clear audit trail to enable the staff to know what medicines people had received. There were adequate storage facilities for medicines including those that required refrigeration or additional security.

We saw medicines being given to people on the first day of our inspection. Staff practice was inconsistent. The nurse giving medicines used humour to positively engage people and knew the needs of most people, such as if they had swallowing difficulties or how they liked to take their medicines. The medicines round took over two hours to complete. This meant some people did not get their medications at the right time; this would also alter the timing of the next dose of some people's medicines. We asked the nurse about this issue. They told us "I know which residents it will be a risk to and withhold it " and give people their medicines later.

The nurse did not consistently demonstrate good hand hygiene when giving medicines. For example, they washed

Requires improvement

Is the service safe?

their hands prior to administering one person's eye drops (gloves were not worn for this procedure) and they did not wash their hands after the administration of the eye drops before preparing another person's medicines.

At no time did the nurse use any system to confirm people's identity prior to administering their medicines to them. Whilst they may have known most people well, there was one person newly admitted to the home. The nurse stated "I do not know much about this lady except she came from Scotland." When administering this person's medicines, the nurse did not ensure it was the right person or ask how the person would like to take their medicines even though this was the first time that this nurse had administered medicines to them. They 'spoon fed' medicines to this person in a rushed manner; the person began coughing and after a few tablets said "That is enough." Following a pause and encouragement, they took the remaining medicines.

The nurse giving medicines was often disturbed either by other staff asking for advice or to assist with people's care. The nurse also had a phone with them as they had to take calls when required. They told us "If this rings when I'm with a resident I take it to a quiet area to take the call." The PIR stated there had been two medicines errors in the last 12 months; the risk of this happening again was increased as the person giving medicines was being disturbed.

A record was kept of accidents and incidents which occurred in the home, but we found staff recording was inconsistent and not in line with the provider's policy. For example we noted one person had bruising on their hand and their arm on the first day of our inspection. This had been noted in their daily records but had not been recorded in the home's incident book as it should have been. The manager, who reviewed accidents and incidents to ensure that appropriate action was taken, was therefore unaware of these injuries. These had still not been recorded in the incident book on the second day of our inspection despite us raising this issue with the manager on the first day. This meant accidents and incidents which occurred in the home were not accurately recorded and not always analysed to prevent a recurrence.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff had received training in safeguarding adults; they had an understanding of what may constitute abuse and how to report it, both within the home and to other agencies. The home had a policy which staff had read and there was information about safeguarding and whistleblowing available for staff. People were protected from abuse as staff raised safeguarding alerts to the local authority and responded to concerns about people's safety. On the second day of our inspection one relative had raised concerns about two staff member's care practice. This was immediately reported to the local authority safeguarding team by a member of staff.

Risks of abuse to people were minimised because there was a robust recruitment procedure for new staff. We looked at the recruitment records for two recently employed members of staff. These showed the provider had carried out interviews, obtained references and a full employment history and carried out a Disclosure and Barring Service (DBS) check (a check on people's criminal record history and their suitability to work with vulnerable people) before they commenced employment.

People were able to take risks as part of their day to day lives. For example some people who were independently mobile could walk in the home; people were supported by staff or relatives to walk in the extensive grounds. There were risk assessments relating to the running of the service and people's individual care. They identified risks and gave information about how these were minimised to ensure people remained safe. These included assessment of people's risk of developing pressure sores, risk of malnutrition and risk of falls.

There were arrangements in place to deal with foreseeable emergencies. The provider had emergency policies and procedures for contingencies such as utility failures or in the event of a fire. People had individual evacuation plans to follow in the event of a fire within the home. Training records showed staff received fire safety training.

Inadequate

Is the service effective?

Our findings

Most people needed support or prompting to drink. One relative told us their family member "Does not always get enough to drink. I've seen other people have very little to drink when I visit. Most people need help with drinks but don't always get the help. I think staff are so busy they just don't have time." We observed staff offered people drinks; this was mostly at set times such as the morning drinks round and at mealtimes. Some people did not have easy access to a drink. For some frailer people, drinks were out of their reach or they needed support which was not always provided. Staff did not always encourage people to have a drink when they had the opportunity to do so. This was raised with the provider's regional manager who had told us they had found this to be an issue on previous visits to the home. They had asked for improvements in this area but these had not been implemented.

Staff completed records when they helped people to drink; these records showed people were not being encouraged to drink enough. One person's care plan stated that they needed "A minimum of 1.6L of fluid per day"; records confirmed they had consumed only 395ml of fluids over one twenty four hour period. Two other people's care records noted their fluid intake over a twenty four hour period. One person had 570ml and another 395ml of fluids. There were no details of any action taken to supplement this poor intake of fluid for people.

There were mixed views about the quality of meals. One person said "The food could be better. There is a choice, just not my choice, but it has improved since the new chef started." A relative said "The food is brilliant." Some relatives raised concerns about how staff supported people with their meals. One relative said "The staff here are good but there are not enough of them and they do not have the time to persevere with [their family member] to get her to eat enough." Another relative told us "I come to help feed [their family member] just to make sure" they get enough to eat.

We observed the lunchtime meal being served on the first day of our inspection. Some people ate in their own rooms; others ate in the dining area. They sat at tables which were nicely laid; people appeared to enjoy their meal. Three relatives helped their family member with their meal. We were informed that lunch was usually served at 12.30pm. Nine people were seated in the dining room by this time (some had arrived some time before) but meals were not served until 1.00pm This meant that some people had been seated, waiting for their meals for at least 45 minutes.

Staff collected individually plated meals from the kitchen one at a time which meant it was a reasonably lengthy procedure as the kitchen was not that close to the dining area. The carer serving people was called away whilst serving to help another carer provide care; one kitchen assistant then took over serving people. One relative asked if there was "any jelly for dessert" as their family member "liked that." A carer went to the kitchen to ask. They retuned and said "There's no jelly. I did ask but the kitchen doesn't have any." The relative said "I will have to bring some more in then so they have some in the fridge."

The records of people's food intake were inconsistent. It was therefore not clear if some people had enough to eat. The record used should ensure that a description of the meal and a percentage of meal eaten were clearly recorded. One staff member stated that these records were "Not accurate". For example, one person's records stated only "pureed meal"; the amount they had eaten was not recorded.

Staff confirmed these records were used to establish what people had eaten throughout the day and then written in the 'progress notes' in people's care records. We asked care staff what action would be taken if they observed poor food intake. They said that they would "Ensure that the resident was given additional food or snacks throughout the day". People's care records which showed poor dietary intake failed to show any additional snacks or supplements were given to people. The provider's audits of the service showed that some people had lost weight. One person at "high risk of weight loss" had lost 2.4kg. This audit stated "the documentation for this resident's nutritional state was quite shocking and there was no evidence" of the person "being offered supplements or fortified milkshakes."

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A small number of people were able to choose what care or treatment they received if they were given the right information and time to decide. Most people would require support to make decisions or would need others to make decisions on their behalf. Most staff had not yet been trained to understand the Mental Capacity Act 2005 (the

Inadequate

Is the service effective?

MCA) or how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. Staff knowledge and practice was inconsistent. The 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.

The PIR stated 14 people have given another person legal authority to make decisions on their behalf. There were no records to confirm this, other than for one person. The staff member who completed the PIR said they "Did not know where the administrator would have got this information from." This meant people were at risk of others making decisions on their behalf without the legal authority to do so.

Where people lacked capacity to make certain decisions, the MCA code of practice had not been followed. This code explained how the MCA should work in practice. For example, people who used bedrails had a mental capacity assessment completed. Where it was assessed that people lacked capacity to agree to their use a best interest decision had been made on their behalf. People's care plans stated that others had been consulted, such as relatives, GPs or social workers but they had not been consulted at the time the decision was made. Staff from the home had therefore made this decision in isolation.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us their induction was thorough when they started working at the home. There appeared limited opportunities for on-going training or updates; staff training records showed that staff training was not up to date. The overall score for completed training was 57%. The only training completed by most staff was induction and fire drills. Most staff needed to complete basic training or refreshers in topics such as manual handling, safeguarding, health and safety and food safety. Other specific training to meet people's care needs, such as nutrition and hydration and caring for people who may become anxious or aggressive at times still needed to be completed by staff. The provider was aware of this issue but had found it difficult to release staff for training due to staff vacancies.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received formal supervision and annual appraisals to support their professional development. Supervisions were a mixture of group meetings, one to one meetings and observed practice. There were staff handover meetings when they started each shift so that important information about people or changes to their care could be discussed.

People spoke highly of the regular staff who worked in the home. One person said "The staff are happy to accommodate almost anything to make the residents feel at home." A relative told us said "I think the staff are amazing; whatever we ask they are willing."

People had access to health care professionals to meet their specific needs. People said staff made sure they saw the relevant professional for reviews or if they were unwell. One person said "I do see my doctor if I'm not well. They always make sure of that." People's care records showed people saw professionals such as GPs, dentists and district nurses.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Relevant staff had been trained to understand when an application should be made and how to submit one. The PIR stated 12 people were subject to authorisation under DoLS. This was incorrect. We found that although these applications had been submitted to the relevant authority none had yet been authorised.

Requires improvement

Is the service caring?

Our findings

Staffing numbers did not meet people's care needs. On both days we observed people in communal areas and in their own rooms who had no interaction with staff for periods of time. There were many occasions when people had to wait for their care needs to be met. People were informed of the delay, which was due to the pressures of staffing numbers. Staff worked extremely hard. They were very busy, but their work was often based around completing tasks; they struggled to meet people's personal care needs and there were very limited opportunities to spend quality time with people.

Staff views on the quality of care they provided was mixed. Staff said people's basic care needs were met but people often had to wait. Every member of staff spoken with said staffing levels needed to be increased to enable them to consistently meet people's needs. One staff member said "It's a huge challenge to be able to meet all the resident's needs due to the shortage of staff; often the residents are still getting up as late as 12:30pm." Another staff member said "People do have to wait for care. Overall care could be better if we had more staff. We are rushed, always working flat out." Some relatives who had completed the home's 2014 stakeholder survey said "There seems to be a bit of an atmosphere and some tension; staff are often in a hurry or too busy to cope."

Staff were very calm, caring and dedicated despite working in challenging circumstances due to staffing numbers and a shortage of permanent staff. They provided care in a dignified way, treating people with respect at all times. Permanent staff had a good knowledge of each person and spoke about people in a compassionate, caring way. One person said "The staff are excellent and that they treat me very well." One visitor said "Staff treat this like home for both of us (meaning them and their family member) which is really nice."

Throughout both days of our inspection staff interacted with people who lived at the home in a caring way. One staff member said "Some people are quite happy with the care." There was a good rapport between people; some chatted happily between themselves and with staff. One relative told us "Being here is like a family."

Some care plans recorded people's background and their interests and hobbies, but this was inconsistent. People's religious or cultural needs were assessed when they first moved to the home. People told us had seen or received a brochure when they first moved to the home. This explained the services and facilities offered. Information about the type of care and support offered was also available on the provider's website.

People we spoke with told us they kept in touch with their friends and relations. They were able to visit at any time and always made welcome. People could see their visitors in communal areas or in their own room. One person told us "My daughter comes in every day. I always look out for her." A relative said they "Popped in at all times of the day and evening; the staff are always very happy to see me."

Staff respected people's privacy. Most rooms at the home were used for single occupancy; one couple shared a doubled room. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home.

People in the home needed assistance with personal care. One relative said "They are pretty good with things like that. [Their family member] had her hair done last Wednesday in the salon which she very much enjoyed." We saw bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. Staff always knocked on doors and waited for a response before entering these rooms. We noted that staff never spoke about a person in front of other people at the home which showed they were aware of issues of confidentiality. People's records were kept securely.

People were involved in some decisions about the running of the home. Resident's and relative's meetings were held so people could express their views about the service. Records of the meetings showed they were reasonably well attended by people and their friends or relatives. A wide range of topics were covered and ideas for improving the service were considered. However, these were not always acted upon. For example at the meeting in November 2014 concerns were raised about low staffing numbers and lack of activities for people. These issues had not been resolved.

Inadequate

Is the service responsive?

Our findings

When we last inspected this service in September 2014 we found the provider had not ensured that people were protected against the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Following the inspection the provider sent us an action plan which set out the improvements they intended to make. These would be completed by 30 October 2014.

At this inspection we found people were not consistently protected against the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

People who wished to move to the home had their needs assessed to ensure the home was able to meet their needs and expectations. This assessment was then used to create a plan of care once the person had moved into the home. The care records for one recently admitted person were poor. There was nothing documented in the daily notes about their admission to the home, their transition or their well-being on admission. Records not completed included their medicines, falls assessment, a list of their belongings, manual handling profile or a continence assessment. The records which had been completed were contradictory. For example, staff had stated this person was not at risk of malnutrition. However, the nutritional assessment indicated a high risk and a high risk had also been indicated in this person's transfer letter. This meant this person was at risk of inappropriate care and treatment.

People's weight records were poor. Several care plans stated people were at risk of malnutrition and therefore needed to be weighed weekly. This was inconsistent. For example, one person was weighed weekly; they were not then weighed for two months. There was no rationale for the change in frequency or any change noted in their care plan. This meant should this person lose weight this may not be identified and acted upon.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always respond appropriately to people's changing needs. One person had a recent skin tear on their right arm. There was no identified cause of injury, no dressing applied, no care plan, wound assessment or treatment plan for cleansing the wound. Another person had developed a sore on one part of their body. There was no formal assessment of the area, no photograph taken, no plan of care or treatment or any evidence of community pressure care specialist being involved.

People told us they were not involved in planning and reviewing their care. One person said "It isn't discussed with me." There was no evidence of people's involvement in their care plans. Plans had been written in the first person (such as "I wish to be given assistance to wash") but there was no record of how or when the person contributed. There was also no evidence of relative's involvement in care planning processes.

There was inconsistent completion of "This is Me" or similar documents designed to gain a life history of each person to inform their care planning and support. There was no evidence of personalised care planning. For example, a care plan for the use of bed rails was in place for several people. This had been photocopied and each person's name simply placed in the appropriate space.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a programme of planned activities each week. This included sing alongs, walks in the garden, bingo and film afternoons. There were mixed views about them. One person told us about the recent garden party. They said "I had had a great time chatting with a number of residents and relatives." Another person told us "There is not much one to one time, but in the lounge it's better." One relative said their family member "Prefers his own company and he is happy here, but sometimes we think the staff could encourage him out of his room where he stays all of the time."

One member of staff organised the activities and led sessions during the week, although we did observe them also helping with care tasks such as helping people with drinks and transfers using a hoist. One person said "The activities co-ordinator is a gem." This staff member told us "People can choose activities. I do some one to ones in the morning and a group activity in the afternoon. We have no transport; some people would like to go out but we can't take them." On weekends care staff needed to organise and lead activity sessions, although this was very difficult in view of the staffing issues.

Inadequate

Is the service responsive?

Staff said they had very limited time to spend engaging people in activities. One staff member said "Most people spend their day in the lounge or their own room. There are a few activities in the week. Nothing much happens on weekends. That's an area we need to address."

There were limited opportunities for people to go out, although many people told us they enjoyed going out and this was noted in some people's care plans. It was therefore difficult for people to continue to be involved in their local community. The home did not have any transport for people; staffing issues also meant staff were not available to take people out. People therefore had to rely on their relatives to take them out or they needed to pay to use transport provided by an organisation that provided accessible vehicles for community groups. One person said "It would be good to have more trips out. The family take me out sometimes." A relative told us "They used to have a minibus for visits but now nothing."

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

People made some limited choices about their day to day lives. One person said "I usually chose to sit in the lounge." Another person said "They do ask you, but they always seem so busy so sometimes you just don't ask." We saw that some people used communal areas of the home and others chose to spend time in their own rooms. People had a call bell to alert staff if they required any assistance. They told us these were not always in reach or answered quickly. We saw some people used their call bells but some people's call bells were not in reach. The staff response to call bells was mixed depending on how busy they were.

People were supported to maintain contact with friends and family. There were friends and relations visiting people on both days of our inspection. One relative said "I usually visit every day. I came at all different times." Some people went out with their relatives. One relative said "I'm taking [their family member] home this weekend. They love spending time at home."

People told us they would not hesitate in speaking with staff if they had any concerns. The provider had a complaints procedure in place. People knew how to make a formal complaint if they needed to but felt issues could usually be resolved informally. One person said "If I have a problem I go down there and get it resolved. I always talk to staff and am happy to raise a concern or make a complaint." A relative said "I would be happy to raise a concern or make a complaint but have not had to do so yet."

There was a register of complaints the service had received. The PIR stated there had been 30 written complaints in the last 12 months. Records showed complaints were taken seriously and investigated in line with the provider's policy. Where themes were identified, such as poor communication with relatives, they had been acted upon.

Inadequate

Is the service well-led?

Our findings

When we last inspected this service in September 2014 we found that the provider had not always protected people against the risk of inappropriate or unsafe care as the quality monitoring of the service did not always identify, assess and manage risks relating to the health, welfare and safety of people. Following the inspection the provider sent us an action plan which set out the improvements they intended to make. These would be completed by 30 November 2014.

At this inspection we found the provider regularly audited the service however when issues were identified they were not always acted upon to ensure people were safe and receiving the care they required.

Staff carried out a number of audits and checks designed to monitor safety and the quality of care. These included audits of care plans, staff hand hygiene and infection control. The regional manager visited the home each month to review the quality and safety of the service and then compiled a report of their findings. In their May to June 2015 report it was noted that care records were not being completed accurately, staff were not adhering to the provider's medicines policy and procedures, there were issues with people's meals and drinks and there were not enough regular staff. None of these issues had been resolved or staff practice improved. Accidents and incidents which occurred in the home were recorded but not always analysed to try to prevent a recurrence.

There were systems in place to share information and seek people's views about the running of the home and areas for improvement. People shared their views but these were not always acted upon. One relative said "We do talk about things at the meetings but things don't always get done. We have been promised fewer agency staff for over a year but we still have them here every day." In addition to the resident's and relative's meetings, the service used an annual stakeholder survey and reviewed complaints and compliments to develop the service.

The 2014 stakeholder survey showed nine relatives and 11 members of staff had completed the survey. These showed mixed levels of satisfaction with the service. Relatives had scored cleanliness and décor of the home and quality of meals highly. Staff had scored most areas highly including safety, cleanliness and décor, dignity and respect and promoting independence. The lowest scores from relatives included people having the right level of help when they needed it, staff being available when needed, sufficient activities and having access to drinks and snacks. The lowest score from staff was for activities on offer. We found the lowest scoring areas had not been improved since this survey was conducted.

Staff from one local authority who fund people's care at this home visited in July 2015 to carry out their own review on the safety and quality of the service. The report summary concluded "This was a disappointing visit which identified many contractual shortfalls." There were 35 areas where significant improvements were found to be required including staffing and staff training, care planning, people's decision making, nursing care, assessing risks and medicines management.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of leadership 'on the floor' where care was being delivered. The provider expected the registered nurse to lead the care team on duty. We observed the nurses were involved in tasks such as dispensing medicines which meant that care staff were unsupervised for prolonged periods of time. This was compounded by the use of agency staff, some of whom were not familiar with people's care needs or the home's routines.

On the first day of our inspection we wished to speak with one person newly admitted to the home. We were unable to find them. The registered nurse and care staff assisted by looking for this person. A member of the housekeeping team then informed us a relative had taken this person out. We then informed the registered nurse and care staff on duty that this person was not on the premises. Neither the registered nurse in charge of the shift nor care staff were aware this person had been taken out.

The last registered manager left the home in August 2014; there had been a lack of consistent management and leadership since then. A temporary manager had overseen the home for several months. A new permanent manager had then started work in May 2015 and a new deputy manager in July 2015. The new permanent manager had begun the process of registering with us. They came in to support the first day of the inspection although they were on annual leave. They had already began to implement some changes such as trying to adopt a more 'person

Inadequate

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centred approach' to the care being provided and trying to increase staffing numbers. One relative said "I think the new manager will be really good but they need to be given time to sort this place out." One staff member said "The new manager is good. Given time, she will make sure things improve. She has a good rapport with staff already." The provider then advised us on the 2nd day of the inspection that this person's employment was to be reviewed at their probationary meeting on the 10th August 2015. The new permanent manager subsequently resigned on the 9th August 2015.

The provider's mission statement said the home provided "Staff who are trained to the highest standards", a "Scrupulously safe environment", "Outstanding emotional care" and "Outstanding high standards of personal care and nursing care." These aims had not been put into practice.

Staff at the home were trying to build and sustain links with the local community. This was hampered by the lack of transport. Some people went out with friends and relatives. No trips out were currently organised by staff. People were invited into the home to attend social events, such as the recent party held in the home's gardens. Links with the local branch of the Women's Institute had been made with visits from them planned. A 'Pets as Therapy' dog visited regularly with their owner.

The provider had notified us of significant events, such as deaths, which have occurred in line with their legal responsibilities.