Saffronland Homes

Nuffield Care Centre

Inspection report

Haigh Crescent
Redhill
Surrey
RH1 6RA

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31 January 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Nuffield Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Nuffield Care Centre is registered to provide nursing and personal care for up to 35 people. There were 24 people living at the service at the time of our inspection.

This inspection site visit took place on 31 January 2018 and was unannounced.

There was a registered manager in post on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 21 July 2017 we asked the provider to take action to make improvements in relation to people's safety, staffing levels and training, the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), the involvement of people in their care, how people were respected, activities and the leadership at the service. We found that these actions had not been completed.

The lack of strong and effective leadership has had an impact across all five key questions that we ask. There had been continued breaches of regulation over two inspections and despite action plans being sent to us to say that the required improvements had been made we found that this was not the case.

There were not sufficient staff to meet the needs of people. People were left waiting for care and at times left isolated due to the lack of available staff. Nurses were often providing personal care to people to support care staff which meant that their nursing duties were not being carried out appropriately.

Staff were not always following good infection control practice. Sluice and medicine rooms were not always clean and waste was not disposed of appropriately. There were some areas in the service that required cleaning and equipment needed updating which was putting people at risk. We did see some good examples of staff washing their hands and using protective equipment when attending to people's personal care. Paperwork relating to people's care was disjointed and staff did not always know where to locate the care records for people.

People who were at risk of dehydration were not being prompted enough to drink and staff were not effectively monitoring this. Records of when cream was being applied to people's skin were not completed appropriately and it was not clear if the cream had been applied or not. Other records were not always being completed appropriately including when how often people required repositioning in bed. This had been raised as a concern by the Coroner in relation to the death of a person using the service.

There were aspects to the management of medicines that were not safe. Reviews of people's medicines relating to their mental health and dementia were not taking place. Charts were not being routinely used to assess whether people were in pain particularly those that were unable to communicate verbally. Body maps were not being used to show staff where creams needed to be applied.

The premises and equipment was not always in good order. Chemicals were not being stored in a safe way and equipment in areas of the service needed updating or replacing.

Not all staff had received supervisions and nurse competency had not always been assessed. Staff were not up date with their mandatory and clinical training. Staff had not ensured that decisions for people had been undertaken in their best interests although decision specific Mental Capacity Assessments (MCA) had taken place.

Staff were not effectively informed about people which impacted on how care was provided. There were a high number of agency staff at the service that did not know people's needs. People did not always have access to appropriate health care professionals in relation to their ongoing care. The environment was not appropriate for the needs of people living at the service particularly those living with dementia.

There were mixed responses from people about the caring nature of staff. We found that people were left isolated without meaningful interactions from staff. People did not have choices around when they wanted to get up. Staff did not always have time to support people in a meaningful way. However when staff did interact with people this was done in a caring and respectful way.

People told us that they were bored. We found that there were insufficient meaningful activities for people to participate in. Actions from complaints responses were not always actioned to show that lessons had been learned.

Quality assurance was not always robust and there was a lack of leadership at the service. The issues we identified on the inspection had not been recognised through the registered managers and providers monitoring of the service. Where people had raised ideas about improvements this was not always followed. There were aspects to the quality assurance that were effective in relation to audits of care plans, health and safety and medicines.

There were aspects to the medicines and risks to care that were being managed well. Risks to people's mobility and those that were nutritionally at risk were managed in a safe way. Accidents and incidents were recorded and action taken. There were appropriate plans in place in the event of an emergency. There was a robust recruitment process in place to ensure only suitable staff were employed.

People told us that they liked the food at the service. There were occasions where people did have the input from health care professionals where needed including GP and Speech and Language Therapists (SaLT). People's needs were assessed prior to moving in to ensure that the service was appropriate for them. Care and support was planned and delivered in line with current evidence based guidance.

People were able to personalise their rooms and visitors were welcomed to the service any time they wanted. Care plans were detailed in relation to people's individual needs including mobility and nutritional needs. Wound care management was detailed with appropriate guidance for how to dress the wound. People were supported at the end of their life to have a comfortable, dignified and pain-free death.

Staff told us that they felt supported and could go to the registered manager when they needed.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Staff had informed the CQC of significant events.

The overall rating for this service is 'Inadequate' and has been placed into '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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not sufficient staff to safely meet the needs of people. Robust recruitment checks were in place that ensured that only suitable staff worked at the service.

Risk assessments were not always being undertaken where there was a need. Where people required repositioning in bed this was not being carried out in accordance with their care plans.

Medicines were not always managed in safe way. We did see aspects of safe medicine practices.

Staff were not always following good infection control practices. The environment was not always being maintained to keep it safe for people.

People said they felt safe. There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

There were appropriate plans in place in the event of an emergency at the service.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were not acting in accordance to the Mental Capacity Act 2005. People's capacity had been assessed however there was no recording of the decisions being made on their behalf including in relation to their DoLS applications.

Staff were not always competent to carry out their role and training was not always provided.

People did not always have access to health care professionals specific to their needs.

The environment did not meet the needs

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always have time to spend with people. People did not always have a choice around their care delivery.

Staff did treat people with dignity and we saw occasions where staff were kind and attentive.

People's relatives and friends were able to visit when they wished. People could personalise their rooms in a way they wanted.

Is the service responsive?

Requires Improvement

There were not sufficient activities for people to be involved in. People told us that they were bored.

Complaints were investigated however improvements were not documented where necessary.

There were some care plans that were person centred and included guidance for staff around how care was to be delivered. People at the end of their lives were provided with considerate care and their wishes were accommodated.

Is the service well-led?

Inadequate

The service was not well-led.

There continued to be breaches of regulations from previous inspections.

There was not adequate management and leadership at the service.

Quality assurance processes were not always effective and were not always used as an opportunity to make improvements.

Staff told us that they felt supported.

Notifications that are required to be sent to the CQC were being done.

Nuffield Care Centre

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 site visit took place on 31 January 2018 and was unannounced. The inspection team consisted of one inspector, two specialist nurses and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is because we were following up on breaches from the previous inspection. The PIR 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. We were also following up on concerns that were raised by the Coroner's office in relation to wound care management and concerns raised by the Quality Assurance team from the Local Authority.

During the visit we spoke with the registered manager, the provider's general manager, 14 people, one relative and nine members of staff. We looked at a sample of six care records of people who used the service, medicine administration records and training, supervision and three recruitment records for staff. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service.

Inadequate

Is the service safe?

Our findings

At the previous inspection in July 2017 we found that staff were not deployed in a way that provided support to people when needed. At this inspection we found that this had not improved and we identified that the staff levels were still not sufficient to meet people's needs.

We asked people whether they felt there were enough staff. Comments included, "They could do with more", "They [staff] are always busy", "The other day there was only two of them [staff]", "There is not enough staff. Sometimes it's dreadful" and "The staffing levels are not good."

There were not enough staff to meet the needs of people. We found that personal care extended until late in the morning meaning people were not always getting out of bed when they wanted. One person was calling out from their bed at 11.05, "Please come. I want to get up." We asked the person if they had alerted staff that they wanted to get up and they told us that they had. They said they were told they needed to wait for two members of staff. They said, "I feel deserted." We asked staff if they could assist the person and they did then go into their room to provide personal care. On another occasion one person who was sat in the lounge had their wound dressing come off and the wound was leaking. We asked a member of the care staff to ask the nurse to change the dressing but they were unable to do this for another 50 minutes as they were busy elsewhere. In the afternoon people were left alone in the lounge for long periods of time with no social interaction from staff. The registered manager told us that staff were busy providing personal care to people in their rooms. We asked people in the lounge how they would alert staff if they needed. One told us, "I would shout for someone." Another said they would, "Get up and walk out into the corridor and call for someone." As staff were often in people's rooms providing care they may not have heard people calling for assistance.

We asked the registered manager how many staff there should be based on the needs of people that lived here. They told us that there were six care staff and two nurses split equally between the two floors and that this reduced to five care staff and one nurse in the afternoon. They told us that 10 out of the 11 people on the ground floor required two staff to assist them and 10 out of 13 required two staff for support on the first floor. We observed that the nurse on each floor was assisting the care staff to provide personal care to people. One nurse told us that, as a result of having to help the care staff, they were behind with their clinical duties including staff supervisions and paperwork. Another member of staff said, "When the nurses are helping [with personal care] we can cope. Without that nurse it would be very difficult and take longer. If we had an extra carer people would get people up sooner." Another member of staff told us, "Sometimes it can become a bit difficult and we can do with an extra hand. Today was very busy which is why the staff nurse was helping to assist with personal care." Even with the assistance of the nurse people were still waiting long periods of time for their personal care.

They registered manager told us that recently the care staff numbers had reduced because the occupancy of the service had reduced. They told us, "There is a situation. The nurse is counted as hands on but in an ideal world they wouldn't be the carer. Staff levels have reduced and I have tried to argue it." They told us that ideally nurses should be reviewing food and fluid charts and care plans instead of providing personal care.

They told us that they were aware through a care plan audit that these were not as updated as often as they should have been.

As there were not sufficient staff to meet the needs of people this is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that they felt safe with staff. One person said, "I couldn't be better looked after and I feel very safe". Although people told us that they felt safe we found that people were at risk of unsafe care.

People were not always protected against the risk of infection as appropriate measures were not in place. In one of the sluice rooms we observed that one of the bins for clinical waste was full and overflowing. An extra bag was placed on top of it which was also filled and overflowing with clinical waste. As a result staff were using the ordinary waste bin to hold clinical waste bags risking cross contamination. The sluice machine in this room was dirty with grime around the groove of the lid. In another sluice room there was no lock on the door or keypad to prevent people from entering, and the room was dusty and unkempt. There were two open bags of clinical waste inside of which one was perched on top of a commode and one on the floor next to the bin. The bin was too small for the amount of clinical waste that had accumulated over the morning. The sluice pan was dirty. There was a toilet riser seat on the floor next to the sluice machine and urine bottle holders were covered in dust.

Staff did not always adhere to basic infection control measures. Staff told us that the housekeepers cleaned the commodes and they were not cleaned between each use. Commodes and bedpans should be cleaned with an appropriate cleaner between every use to reduce the risk of infection. There were large cobwebs on both windows in the hairdressing room and the upstairs bathroom was found to be untidy and full of dusty equipment. There was no pedal bin in one of the medicine rooms and staff were observed discarding waste in a yellow bag placed at the bottom of a cupboard. There was a service policy in relation to infection control however this was not always being followed by staff.

We did see staff washing their hands regularly and using gloves when attending to people's personal care needs. The laundry room was clean and well set up and laundry was washing adhering to correct infection control.

Risks to people's care were not always managed safely. There were people that were at risk of dehydration and required prompting with drinks through the day. We found that staff were not always prompting people sufficiently. For example one person was observed to have three full cups of drinks in their room including a cup of tea that had gone cold. We did not see staff assist this person to drink. The person's fluid records did not state that the person was offered a drink and refused. Their care plan stated that they needed encouragement with fluid intake. Another person required regular prompting to drink yet their relative told us, "Mum needs more encouragement to drink from staff." They told us that they kept having to remind staff to do this.

People who were at risk of skin wounds did not receive safe care to minimise them forming, or getting worse. One person had a wound on their bottom. Although the wound was healing care records stated that staff were to ensure that they were regularly applying cream to reduce the risk of the wound reappearing. The records of their cream application indicated that this was not always being done. For example over a five day period cream was only applied on three occasions. This put them at risk of their skin condition worsening.

Specific risks from medical conditions were not always identified, nor guidance given to staff on how to care for the person. One person had a particular condition that meant that they were at a high risk of stroke. There was no risk assessment in relation to this to ensure that risk of stroke was minimised. One nurse that we spoke to was unaware of what this condition was. There was a risk that the person in charge of giving emergency care would not then know how to give care and support to keep that person safe.

There were aspects of the administration of medicines that were not safe. Pain charts were not used for people who were unable to communicate when they were in pain. This meant that staff may not be able to identify the appropriate signs when people required pain relief. Where people had creams applied there were no body maps to show where the cream needed to be applied.

The paperwork relating to people's care was disjointed and was located in various places including daily log books, paper care plans and on the computer. We found it difficult to establish the most up to date care for a person. There were a high number of agency staff at the service. On the day of the inspection two members of staff did not know how to locate the care plans for people. This indicated that they had not read people's care plans before delivering care. This put people at risk as staff would not be aware of people's needs. Where staff were completing food and fluid charts there was information for staff on what their target intake should be. Although the nurse on duty audited the fluid intake of people this was done at the end of the week. Having the target information on the chart would be an indicator for staff to alert the nurse if the person's intake was low. There was also no recording of the fluid outtake for people who had a catheter which could indicate whether a person had a blockage.

Failure to safely mange risks to people and the poor management of medicines is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises and equipment at the service was not always stored or maintained appropriately to keep people safe. There was a room situated near the nurses station that was left unlocked and contained COSHH items (chemicals in bottles) that people could easily access. The service policy stated, "Ensure that all storage and transport [of COSHH] vessels are appropriate and adequate." Staff were not following the providers own policy in relation to this. One person's bathroom was in disrepair. Although they were not using the bathroom it was still being used to store their equipment. There were many tiles missing from the wall, the hoist was broken and dusty and should have been removed from the room and there was a toilet pan on the toilet that appeared to have black burn marks on it. There was a washing up bowl situated under the sink in the sluice with a dark green substance in it from a leak in the sink that we had identified at a previous inspection.

As the premises and equipment at the service was not always stored or maintained appropriately this is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people were supported to take their medicines as prescribed. Nurses were available on each shift to ensure people received their medicines at the times they required them and the right dose. People's medicine administration records (MAR) were signed as appropriate and up to date. All MAR charts had a recent photograph of the person for ease of identification. Staff completed medicine's audits monthly to ensure that people received their medicines as prescribed. Records showed that people received their medicine in a timely manner. Medicines were stored in a locked trolley in locked clinic rooms and the keys were kept by authorised staff only. Medicines that required to be kept in the fridge were stored in the fridge. Temperatures of the fridge and room were taken daily. For those people that were diabetic the staff monitored people's blood sugar before the administration of insulin.

There were aspects of care that were safe. Assessments were undertaken to identify other risks to people. The care records had risk assessments in place including malnutrition and moving and handling. The registered manager had systems in place to audit all accidents and incidents. We reviewed this and found that there had been no recent incidents or accidents recorded. There were appropriate plans in place in the event of an emergency. In the event of an emergency such as a fire each person had a personal evacuation plan which was reviewed regularly by staff. Staff understood what they needed to do to help keep people safe. There was a business continuity plan in the event the building needed to be evacuated. People would be supported by the providers other care homes.

People were protected from being cared for by unsuitable staff because robust recruitment was in place. We saw that there was an up-to-date record of nurse's professional registration. All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms had been fully completed; with any gaps in employment explained. The provider had screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection in July 2017 we found that the requirements of the Mental Capacity Act 2005 (MCA) were not being followed. People had not been assessed in relation to their capacity to make specific decisions. Where decisions were being made for people there was no evidence to show that this was in their best interests. We found on this inspection that this had not improved.

The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

We found that although specific assessments were taking place in relation to people's capacity these were not followed up with evidence of a best interests meeting. For example there were people that lacked capacity that had bed rails in place. There was no evidence of any meetings to detail how they came to the decision that this was the least restrictive option, or if it was in the person's best interests to have them. The registered manager was unable to explain why there was no evidence recording of when best interests decisions had been made. We noted that DoLS applications had been completed and submitted to the local authority for people living at the home where restrictions were being placed upon them. As there was a lack of decisions recorded it was not clear whether it was in the person's best interests to be restricted.

As the requirements of MCA and consent to care and treatment were not followed this is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in July 2017 we identified that staff did not always have the knowledge and skills required to support people. On this inspection we found that this was still a concern.

Staff were not sufficiently qualified, skilled and experienced to meet people's needs. The registered manager provided us with the matrix used to record the training staff had received. Out of 33 staff four had not received manual handling training, five had not received first aid training, four had not received infection control training or fire safety training and 11 had not had up to date dementia training. The training policy for the service stated, "Staff duties: attend all statutory and mandatory training requirements" however this policy was not being followed. The clinical training for nurses was also not up to date. According to the mandatory training matrix three nurses had not received training in diabetes, the registered manager who worked as a nurse had not had any training in diabetes since 2010, three had not had training in nutrition or tissue viability and only one member of staff had any training in mental health conditions. There were people at the service that had a mental health diagnosis.

Staff did not always have supervisions to ensure they were competent to provide care safely. According to the service policy staff were required to have two supervisions per year. We reviewed the supervision records

and found that 12 staff had not had a recent supervision. Clinical competencies of the nurses had also not been assessed appropriately. The registered manager told us that they had undertaken competency assessments for nurses. When we reviewed the assessments we found that although nurses were having occasional group supervisions there was a lack of one to one clinical supervisions with the registered manager. One nurse had not been involved in any group clinical supervision or one to one clinical supervision. Nurses had been assessed in relation to their competency to administer medicines.

There was a lack of effective information sharing between staff that impacted on how care was provided. Most of the care staff at the service were agency staff. People we spoke with commented on the high use of agency staff and felt that this affected the care provided. One told us, "They [agency staff] don't know who we are and we don't know them." Another told us, "When we get agency that have not been here before it's hard." A third said, "They [staff] are always changing and they don't know me." There was a printed hand over sheet with room numbers, people's names, their medical needs and additional comments however these sheets were only given to nurses. Information on the handover sheet was not always easy to understand and the nurse on duty was unable to explain two people's medical conditions. We asked staff how they acclimatised agency staff who did not know the service and we were told that agency staff would work with a more regular member of care staff who knew people. However one person fed back that this was not always the case and found they had to often explain their care routine to agency staff which they found frustrating.

We asked how care staff returning from annual leave or sickness were given an update when returning and we were told they could read the daily log books after the morning shift had finished. This put people at risk as staff attending to the needs of people did not have up to date information about them.

As there was a lack of staff training, knowledge and competency this is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have access to appropriate health care professionals in relation to their ongoing care. There were people that had a diagnosis of dementia and there was no evidence of support for the treatment of their condition from the Community Psychiatric Nurse (CPN). Another person who was registered blind said they would like to have input from the Blind Association. They said that they had this at their previous home and that, "I never get to find anything out now."

The environment was not always set up to meet the needs of people living at the service. People that were wheelchair users were able to move around independently. However there were seven people that were living with dementia where improvements were required to ensure their needs were being met. The registered manager told us, "We don't have a suitable environment with dementia." They told us that they would not admit people if their primary need was a diagnosis of dementia. We found that the chairs in the lounge were arranged around the edge of the wall instead of small clusters to encourage conversation. There was a lack of appropriate points of interest for example photographs or artworks of a size that could easily be seen, along the corridors.

As people did not always have access to support for their care and treatment from outside professionals and the environment did not always meet people's needs this is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the food had improved in the last few days with the recruitment of a new chef. One person told us, "The food isn't too bad. You get a good choice." Another told us, "The food is marvellous now."

We observed lunchtime which was pleasant with a reasonable amount of conversation. Staff supported people with their meals when required. Staff explained to people what the meals were and reminded people what they had chosen. Staff were cheerful and friendly and there was soft music playing in the background. The food looked appetising and was nicely presented however there was one person who stated that their pureed meal was not very tasty. We saw that this had been raised by this person on more than one occasion at a residents meeting. There was no evidence that this had been addressed. When we spoke to the chef they confirmed that people on soft diets were not given choices however they did say that they were going to address this. People also fed back that they would like to see menus on the table so that they knew what the meals were. Again the chef told us that they were going to address this.

There were occasions where people did have the input from health care professionals where needed. There was evidence in care plans that a range of healthcare professionals were involved including a district nurse, GP, occupational therapist, physiotherapist, optician and dentist. Where people had lost weight this was monitored carefully by staff and where necessary dieticians and speech and language therapists were involved in their care. One person told us, "You tell the staff and they get one [GP] for you".

Prior to moving into the service people's needs were assessed to ensure that the service was appropriate for them. Although care and support was not consistently planned and delivered in line with current evidence based guidance; there were examples where this was done. For example from the National Institute for Health and Care Excellence, British Journal of Nursing, Royal College of Nursing and NHS England.

Requires Improvement

Is the service caring?

Our findings

There were mixed responses from staff about the caring nature of staff. Positive comments included, "Very caring", "Very good", "Very nice indeed" and "I am well looked after". Other people fed back, "The night staff don't talk nicely to me, they are abrupt and they don't care" and "The nurse came in today and did not even say good morning. I feel so hurt."

We found that people were not always treated in a caring way as staff were focused on their tasks. There were times that people were left in the lounge or their room as staff were busy elsewhere. This impacted on people's mood and wellbeing. One person was in the lounge with six other people in the afternoon. They told us that they had nothing in common with anyone and sat away from the other people in the lounge due to their inability to communicate with them. Staff had not ensured that they had meaningful conversations with the person. The person said, "I'm fed up to the back teeth." Another person told us, "I'm so miserable" and another said, "I'm so fed up. I'm not interested in what's on the telly." The television was on the wall and was too high and far away for some people to see adequately. Staff had not asked people what they wanted to watch and we asked staff to address this.

People's choices were not always accommodated. People did not have the choice of when they wanted to get up. One person told us, "I don't have a choice. In an ideal world 09.30 I would like to get up. You just have to wait in line." Another person told us that they needed help sorting what clothes they want to wear from their wardrobe as they were registered blind. They told us, "I find it very hard finding clothes but If I ask staff for help they haven't got the time. I ask them to put clothes on my bed but they don't do that."

As people did not always have choices around their care delivery and did not have meaningful interactions with staff this is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe some kind and caring interactions with people. We saw an example of a member of staff providing reassurance and comfort to a person who was upset. On another occasion a member of staff assisted a person to put on their cardigan who said they were feeling cold. When staff had the opportunity to spend time with people they did so in a courteous way.

We looked at care plans in order to ascertain how staff involved people and their families with their care as much as possible. We found evidence that people and/or their representatives had regular and formal involvement in ongoing care planning. There were times that people were encouraged to be independent. One person delivered newspapers to people's rooms each day. Another person had collections of books that staff supported them to store in their room.

When staff provided personal care to people this was provided behind closed doors to protect people's dignity. We observed staff to knock on people's doors before they entered. When staff spoke with people they did this in a polite and respectful manner.

People were able to personalise their room with their own furniture and personal items so that the rooms felt more homely. We saw that family and visitors were able to visit the service whenever they wanted.

Requires Improvement

Is the service responsive?

Our findings

On the inspection in July 2017 we found that people were not being provided with meaningful activities that they enjoyed. On this inspection we found that this had not sufficiently improved.

We asked people whether they felt there were sufficient activities for them to take part in. One person told us, "There is not enough going on. I can't do lots of things as I can't see." Another person said, "I enjoy reading but I don't get to do it". We asked people if they had opportunities to go out on trips with staff and they said they did not. One person said, "A mini bus to Worthing would be nice." Another said "It would be nice to have a change of scene." Another told us, "We never have trips. I really would like that. That would be lovely." A fourth told us, "I would like to go out into the garden more but they [staff] don't like us going outside." A member of staff told us, "I would like to be able to take residents out on trips but it isn't currently possible." They were not able to tell us why this was not possible. There were people at the service living with dementia and there was a lack of meaningful activities for them.

During the morning of the inspection there was a cake baking activity taking place in the lounge. However this activity started at 10.00 and there were people that were still in bed that were unable to take part. Once this activity had finished in the morning there were no other activities taking place for the rest of the day. The activity coordinator told us that activities were not arranged for the afternoon as people, "Are asleep in the afternoons anyway." The activities noticeboard displayed in the hall showed nothing was planned for Monday or Tuesday, and a, "Rest day" for Saturday. When we asked the activity coordinator what a rest day meant they said "People will just sit in the lounge or in their rooms, perhaps watching a film." We observed that the television was on in the afternoon however people were falling asleep due to the lack of activity as they did not have anything else to do.

Care and treatment was not always provided that met people's individual needs. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints and concerns were investigated however there was no action plan in place to show that the complaint we viewed had been addressed with staff. There had been one complaint at the service since the last inspection. The regional manager investigated this and responded in detail to the family to say that lessons would be learned. However there was no record of what actions were actually taken to ensure that improvements were made. After the inspection we were provided with evidence that this had been addressed.

We recommend that actions that have taken place in relation to a complaint are recorded and kept with the complaint response.

Although there was evidence that care was not always being delivered appropriately; the care plans outlined individual's care and support. For example, mobility, health and dietary needs. Any changes to people's care were updated in their care records to ensure that staff had up to date information. For example wound care was detailed and included a wound assessment form with dates of review, updates on the condition of

the wound, what to use to clean and dress the wound and photographic evidence of the wound. Where there were mobility concerns identified there was guidance for staff on how best to support the person for example the use of hoists or walking aids.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Relatives fed back to staff how they felt about the care their loved ones received at the end of their lives. One relative told us, "Mum hasn't got long to go and we are very satisfied. They [staff] suggested that we meet with the local hospice and they [staff] took the time to sit and talk to us about mums care. We have phone calls late at night and we have appreciated that."

Inadequate

Is the service well-led?

Our findings

At the previous inspection we identified that there was a lack of robust quality assurance processes in place. We had met with the provider following that inspection and they had assured us that improvements to the service would be made. They sent us an action plan to advise that all of the actions identified had been addressed. However on this inspection we found that this was not the case and sufficient improvements had not taken place.

The leadership of the service was not always obvious to people and visitors. People were not clear who the manager was. They either assumed the provider's regional manager was the manager or they were just not sure. The registered manager told us they often worked as a nurse covering both floors. We asked them if people's perception may be they were a nurse on duty rather the registered manager which they agreed was probably the case. The service action plan from July 2017 stated that a new deputy manager had been recruited to support the registered manager. However the registered manager told us that the deputy worked for three days of the week and on two of these days they were rostered as the nurse on duty. This left the deputy one day of the week to perform their management duties. There was lack of strong oversight and leadership of the service that impacted across all five of the questions we ask.

There were insufficient quality assurance processes in place to ensure people received the best care. Although there had been residents and staff meetings these were not always used to make improvements. During a residents meeting in November 2017 it was agreed that people would be offered fruit after lunch. We did not see this happen on the day of the inspection. Another resident asked at the meeting if table tennis could be introduced. They asked for this again at the 10 December 2017 meeting and they were told by staff that this would be introduced after Christmas. At the inspection the person told us that this still had not happened. At the meeting in December 2017 another person asked if they could be supported to get up earlier as they were missing out on activities however we found at this inspection that this was still a concern. People were still missing out on the morning activity as they were not receiving their morning personal care in time.

At a resident's meeting on the 28 December 2017 one person raised that they were unhappy with their pureed meals. The minutes stated that the person would have to wait for this to be addressed, "A few weeks" as the resident chef was on leave. At the residents meeting on 21 January 2018 the person raised this again. On the day of the inspection the new chef informed us that they were not happy with the quality of the pureed meals. This meant that the person had to wait over a month before this was addressed. People had also asked for an increase in person centred activities however this was still an issue at this inspection.

Audits that took place did not always identify what we had identified. For example, infection control audits had not identified the poor environment in one of sluice rooms. A fire service audit in November 2017 and December 2017 had not identified that the combustible materials (COSHH) were not being stored in an appropriate place. The service annual development and improvement plan had not detailed the improvement deadlines for example in relation to staff supervisions and training. We also continued to find gaps in staff training and staff supervisions. Although the provider's regional manager was visiting weekly we

did not see evidence of audits that they were undertaking.

Where feedback from people and their relatives was sought action was not always taken to address the concerns raised. We saw from the 2017 survey that comments were made in relation to the lack of outings and more, "Care staff needed." This was still a concern at this inspection.

Although staff attended regular meetings areas that required improvement were still occurring. For example, at a meeting on the 28 September 2017 kitchen staff were asked to record, "What someone had drunk in the morning when they collect the cups." This was not being done on the day of the inspection. Staff were also reminded to record the measurement of urine output of catheters and this still was not being done. There was no evidence on the minutes of staff meetings that staff were asked for their feedback on how to make improvements at the service.

The Statement of Purpose for the service states, "Staffing levels for care assistants are based on the occupancy levels of the home which ensures all needs were met." We found that staff levels were not being assessed on the needs of people. It states, "Services users will contribute to their community as citizens." However we found that this was not happening as people did not have opportunities to access the community. It states, "There are quiet areas within the home for reading and listening to music." There were no rooms at the service that were being used for this purpose.

As there was a lack of leadership and systems and processes were not established and operated effectively this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were aspects to the quality assurance that were effective. Internal audits were completed with actions plans with time scales on how any areas could be improved. Audits were undertaken that covered health and safety, care plans, medication and meals. The manager had an on-going action plan where areas that had been identified were constantly reviewed.

Staff we spoke told us that they felt supported by the registered manager. One told us, "The manager is good." Another told us, "I feel very much supported by the manager. She will always work on the floor and I can go to her when I have a question."

There was evidence that the provider was working with external organisations in relation to the care provision. For example the provider had regular contact with the GP, SaLT, dieticians and other community care teams.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Staff had informed the CQC of significant events.