Barchester Healthcare Homes Limited

Bloomfield

Inspection report

Salisbury Road
Paulton
Bath
Somerset
BS39 7BD

Tel: 01761417748
Website: www.barchester.com

Date of inspection visit:
27 September 2017
28 September 2017

Date of publication:
05 December 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an inspection on 27 and 28 September 2017. The previous comprehensive inspection was undertaken on 21 March 2017. At this inspection the provider had breached three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These breaches related to: Person-centred Care and Good Governance. The service was rated as 'Requires Improvement'. At this inspection we checked whether improvements had been made and the service was no longer in breach of the regulations.

You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Bloomfield, on our website at www.cqc.org.uk

Since July 2013 we have conducted a comprehensive inspection at the service six times. The provider has failed to fully meet all the regulations on all six occasions. Since the previous inspection in March 2017 there have also been repeated breaches of the same regulations. These relate to staffing and failing to submit statutory notifications. We have also identified additional concerns relating to recruitment checks, safeguarding adults, good governance and consent.

"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.

Bloomfield provides accommodation for people who require nursing or personal care to a maximum of 102 people. The accommodation is set over two floors with four separate areas. These are 'Ash Way' and 'Salisbury Rise', which provides general nursing care and treatment to people, and 'Beech Walk' and

'Mendip View' which provides care and support to people living with dementia. At the time of our inspection 69 people were living at the service.

The registered manager had recently left the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. On the day of our inspection the interim manager was on leave. During their leave the service was being run by the deputy manager with support from the senior management team.

At our previous inspection we found the service was not sufficiently staffed to meet people's needs. Since our inspection in inspection in March 2017 we found insufficient improvements had been made.

Recruitment checks had not been consistently carried out in accordance with the provider's recruitment checks policy.

Incidents and accidents were not consistently recorded and investigated by staff to ensure the safety and well-being of people.

At our previous inspection we found that the provider had failed to notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled . Insufficient progress had been made. The service had failed to make appropriate safeguarding and serious incident notifications to the Commission, as required.

People's rights were not consistently upheld in line with the Mental Capacity Act (MCA) 2005. Consent to care was not always sought in line with legislation and guidance because the principles of the MCA had not always been followed. This was particularly in relation to the use of bed rails and sensor mats. Capacity assessment and best interest meetings were not always held.

At our previous inspection people were not fully protected against the risk of unsafe or inappropriate treatment as care records were not properly maintained. The service did not consistently deliver appropriate care that met people's needs. Improvements had been made but this area of their work requires further development.

The observed dining experience was not consistently person-centred.

People and their relatives felt that the staff were caring. Staff spoke highly of the care they provided. Despite their reservations regarding the current staffing levels all of the staff we spoke with said they would recommend the service to people.

Medicines were managed safely.

New staff undertook an induction and mandatory training programme before starting to care for people on their own. Staff were consistently supported through a regular supervision programme. Supervision is where staff meet one to one with their line manager.

People's nutrition and hydration needs were met. People's nutritional needs were assessed and where risks were identified, specialist support was sought.

There is a full weekly social activity programme. Some people chose not to participate and this was respected.

People maintained contact with their family and were therefore not isolated from those people closest to them.

Staff felt well-supported by the deputy manager. The deputy manager held a regular programme of staff meetings to advise them of operational and clinical issues which required actions. This line of communication has resulted in improved recording, particularly regarding risk management.
To enable people to provide feedback on their experience of the service resident meetings were held.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations. We are currently considering the action we are taking.

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.

The service was staffed in accordance with the level determined by the provider's staffing tool. However, feedback received and our observations highlighted that insufficient staff were deployed to meet people's care needs.

Recruitment checks had not been consistently carried out in accordance with the provider's recruitment checks policy.

Systems were not consistently operated effectively to investigate any allegation or evidence of abuse.

People were cared for in a safe and clean environment.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not being consistently upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

Staff were supported through a training and supervision programme.

People's nutrition and hydration needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dining experience was not consistently person-centred.

People's care plans for end of life care needs required further development.

People and their relatives felt that the staff were caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were in the main protected against the risk of unsafe or inappropriate treatment as records were properly maintained. Exceptions were found regarding life history and positioning documents.

The provider had a protocol in place to receive and monitor any complaints that were made.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

Is the service well-led?

Inadequate

The service was not well-led.

Since the previous inspection in March 2017 there had been repeated breaches of the same regulations. These related to staffing and failing to submit statutory notifications.

Systems were not operated effectively to assess and monitor the quality and safety of the service provided.

The provider had failed to notify the commission about certain changes, events and incidents affecting their service or the people who use it.

Staff felt well supported by the deputy manager.

To enable people to provide feedback on their experience of the service resident meetings were held. Identified issues were taken forward by the service.

Bloomfield

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. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced inspection on 27 and 28 September 2017. On 27 September the inspection was undertaken by three inspectors and an expert by experience. On 28 September the inspection was conducted by two inspectors 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 care service.

Before the inspection we reviewed the intelligence we held internally about the service and received information from the local authority. On the day of the inspection the service was being run by the deputy manager. The manager was on leave. During their absence the deputy manager was being supported by a clinical divisional nurse three days a week. They told us they also had access to telephone support from the Regional Director, if required.

Over the two days we spoke with 15 people, six visitors, 13 members of staff, the deputy manager, the clinical divisional nurse, the Regional Director and the Operational Director. We observed care and support in the communal areas. We reviewed a sample of the medicine administration records (MAR's) in current use and topical application records. We reviewed 11 care plans and a sample of food and fluid charts and repositioning records. We also reviewed the provider's audits relating to the health, safety and welfare of people who use the service.

The inspection feedback was provided on the 29 September to the deputy manager, Director of Regulations, Interim Divisional Director, the Operational Director and the Regional Director.

Inadequate

Is the service safe?

Our findings

At our previous inspection in March 2017 we received mixed feedback about staffing levels at the service which we reported to the provider. Staffing levels were assessed by following the Dependency Indicator Care Equation (DICE) tool. This tool determines the level of staffing required whilst taking into account the dependency needs of people. We were told by the operations director that the service is currently staffed over the dependency level determined by DICE. The staffing rotas also demonstrated that the staffing levels were in the main maintained in accordance with the figures determined by DICE. There were exceptions. DICE indicated that the night time staffing level should be seven staff (nursing and carers) on duty. During the period 4 September to 24 September the staffing level was six. On two occasions there were five staff on duty. The DICE tool determined that staffing level for Salisbury Rise should be five carer staff during the day and four carer staff during the afternoon. During the day we noted one exception where the day time staffing level was not maintained and two occasions in the afternoon. Beech Walk did not maintain their staffing level of four carer staff on one occasion during the day and afternoon. We were told by the deputy manager that the staffing levels determined by DICE had recently increased owing to a new admission to the service. The regional director advised that DICE overestimates the level of staff level required by 15%.

All of the staff we spoke with said they did not feel there were enough staff on duty to meet people's needs. Comments included "There's not enough staff today because someone is off sick. People have to wait and call bells ring. I feel very pressured"; "Management would say we have enough staff, I would say no. Weekends are a nightmare. We just don't have time to sit and talk or interact with people properly"; "Sometimes people have to wait to get up or they have to wait for their meals because we're busy with other people"; "I do think we need more care staff. Residents with dementia need assistance and this can take a long time"; and "I think people's physical needs are met, but not their emotional needs because we don't have time."

The majority of people and their visitors thought that staffing levels were inadequate at times. Comments included; "They need more girls on the floor first thing in the morning"; "It varies. There are plenty sometimes, sometimes not"; "We need more staff up here. There's a lot of people in bed up here (Salisbury Rise)"; "Sometimes there are enough, sometimes not. Mornings are very busy"; "On the whole I would say they are short of staff. The staff are working flat out when they are here. They are on their feet for 13 hours a day"; "They have cut the cleaner's hours so they haven't got time to get around. It's not as clean as it was"; "The teas and coffees aren't coming round so regularly recently "; "At lunchtimes sometimes there is only one here (Mendip View) and they are pushed. They could do with more staff to help out. I come in to help (at lunch) They get so busy it takes it off their hands"; and "Staffing is a bit better than it was. Staff have no time to talk."

We observed that there did not appear to be enough staff on duty to ensure people's needs were met. All bedrooms were equipped with a call bell system and these were mainly to hand where people could use them. We observed that call bells were not consistently responded to in a timely manner.

At 14.10 in Salisbury Rise, the call bell was activated by an inspector who found a person had soiled in their

bed. After 3.5 minutes a member of staff appeared and they were told about the problem. They went to get another member of staff to assist the person. At the same time (14.10) another person had become very agitated and vocal. Their relative tried to calm them but failed. No staff member appeared to help. The relative activate the call bell at 14.18. At 14.30 a member of staff cancelled the call bell and left. At 14.35 they returned back with a hoist. Another person activated their call bell at 14.20. At 14.30 staff cancelled the call bell and left. The person told us; "I've been waiting for the toilet for an hour and a half. I've rung three times now and no one has come back. They've always got an excuse." At 14.40 staff attended to the person's needs. People's and visitors comments regarding the response times included; "They take longer to answer at night"; "They don't take too long but sometimes come in and switch it off and then go away again"; "I have a water bottle at night (to use instead of the toilet)"; "It sometimes takes a while to answer"; and "That's the trouble they don't come when you ring." We were told by the deputy manager that the system in place does not enable them to audit call bell response times. We were told that the provider is going to incorporate a system to enable reviews of call bell response times.

In the communal areas there was usually a member of staff present although in the morning this was not always the case. We observed from the Amesbury Lounge (Ash Way) people were being accompanied upstairs to the morning activity session on Salisbury Rise and staff were busy elsewhere. At 10.45 one person was sat in the dining area on her own. They had been placed with their back to the doors and looking out of the window. They called an inspector over and told us they were worried they hadn't had their medicines after breakfast. The inspector waited but there were no staff available to assist. The inspector found a member of staff and advised them of the person's concerns.. Staff told us the nurse had been called away with the doctor but would do them soon. A staff member came and reassured the person and the medicines were given within 5 minutes.

Whilst observing lunchtime on Beech Walk, we observed two people who chose to remain in their rooms given hot food by staff, who then did not return for 20 minutes. When they did return with their dessert, both people had fallen asleep and their food had gone cold. Staff told us that they were busy trying to support other people with their lunches and it was difficult to make sure everyone was enjoying and eating their food as "There were only so many staff on duty."

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

Recruitment checks had not been consistently carried out in accordance with the provider's recruitment checks policy. We found for one person the service did not obtain a reference from the individual's current or most recent employer before they commenced employment. The references submitted were from previous work colleagues and not directly from their employer. The policy states; "It is Barchester's policy that you must obtain a minimum of TWO written references, one of which should be from the individual's current or most recent employer before the individual commences employment. It is essential that the candidate has named a referee from their current or most recent employer who is of an appropriate status / level of management i.e. not a colleague or friend they worked with but is a person who had a managerial authority over the candidate." There had been issues regarding this person's performance and they were currently being processed through the provider's disciplinary procedure. We also noted that one reference from a previous employer regarding another member of staff raised performance concerns. It was not documented in their personnel file that the service followed their recruitment checks policy. The policy states; "The manager should arrange to meet with the candidate to discuss the reference obtained and to provide them with an opportunity to explain what has happened." We raised this with the deputy manager. They told us that they were not aware of the reference as this would have been dealt with by the recently departed registered manager. This was not documented on their file.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they had received training on safeguarding. They knew how to identify signs of abuse and knew how to report any suspected incidents of abuse. Despite this knowledge systems in place did not always ensure that possible abuse and improper treatment was investigated promptly. In one person's care plan, we found two separate body maps for unknown marks found on the person's arms and torso. One was dated 8 August 2017 and the other had two dates which were 8 June and 9 September 2017. The body map dated 8 August 2017 was written in the care plan. There was no documented evidence about the body map dated 8 June and 9 September and how the injuries occurred. We spoke with the nurse on duty and deputy manager and they confirmed they had no knowledge of these two body maps and had therefore not been investigated by them. This meant that systems were not consistently operated to investigate every allegation or evidence of abuse. Where incidents had been correctly reported by staff there was a clear audit trail of the investigation and the actions taken to keep the person safe.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans contained risk assessments for areas such as mobility, moving and handling, malnutrition and skin integrity. All of the risk assessments had been reviewed regularly and when risks had been identified, the care plans provided clear guidance for staff on how to reduce the risk of harm to people. When people were unable to move around independently, the plans contained details of any mobility aids the person required. When people required staff to use moving and handling equipment to change their position, the plans detailed the type of hoist and sling that staff should use. Some people's mobility had been assessed as "variable". In these instances the plan detailed the assistance people might require on good days and bad days. For example, in one person's plan it had been documented "uses a walking stick, but variable. Staff to assess and if feeling weak, will require 2 staff, stand aid and small sling." We observed staff using a hoist to transfer one person from a wheelchair into an armchair. They told the person exactly what was happening, provided reassurance during the procedure and ensured the person was safe.

Medicines were managed safely. We observed parts of a medicines round. The nurse administering the medicines knew people well, knew what they had been prescribed and the reasons why. They asked people if they were happy to take their medicines. The nurse took their time when administering the medicines. They gave encouragement and waited until people had swallowed their medicines before signing the medicine administration record (MAR). They asked people if they needed additional medicines, such as pain relief. When one person said no, they said "Just let me know if you need some later." There was a system in place for staff to check that MAR charts had been signed at the end of their shifts. All of the MAR charts we looked at had been signed in full. This indicated that people received their medicines as prescribed.

MAR charts had photographs of people using the service; they had all been dated to indicate they were a true likeness of people. This meant that staff that were unfamiliar with people, such as agency staff, would be able to easily identify people.

Topical medicine administration charts had clear instructions for staff about where to apply creams and lotions and the required frequency. Charts that we looked at had all been completed in full which indicated that people had creams and lotions applied as prescribed.

Some people had been prescribed PRN (as required) medicines, such as pain relief. These were person centred and included detail for staff such as "has a long history of chronic back pain." PRN protocols for

medicines that could be administered if people displayed agitation included details about why people might be agitated and steps staff should take before administering medicines. One person had been prescribed a medicine to be administered by staff in the event of a seizure. The MAR chart did not contain instructions for this medicine. When we showed this to staff it was noted that the previous MAR instructions had not been carried forward. This was immediately rectified and a note added for staff to ensure the instruction remained in place.

Stock controls of medicines were carried out during each medicines round. Medicines that were no longer required were disposed of safely. One person was having their medicines administered covertly. This is when medicines are "disguised" within food or drink. Records showed that the person's ability to consent to have their medicines this way had been assessed. The outcome of the assessment showed the person lacked capacity, and a best interest decision had been made in conjunction with the person's family and other members of the multi-disciplinary team. This was clearly documented and showed how the decision had been reached.

Medicine fridge temperatures and the temperature of the clinical rooms were checked daily. The monitoring charts showed that the clinical room on Ash Way had sometimes exceeded the maximum recommended temperature for the safe storage of medicines. During July staff had documented on five occasions that the temperature had exceeded 25C, but they had not documented if any action had been taken, if the raised temperature had been reported or if the temperature had been rechecked. We showed this to the deputy manager during the inspection who said that staff would have put a fan on and they would instruct staff to document this going forward. Other clinical rooms showed the temperatures were within recommended limits.

Medicine audits had been undertaken. We looked at the latest available audits and the latest pharmacist advice visit. Recommended actions had been completed. For example, the pharmacist had recommended the use of labels to show when bottles of medicines were opened and when they were due to expire. We saw that these were being used.

People were cared for in a safe and clean environment. All rooms were well maintained, hygienic and odour free. A full time maintenance person was employed by the service. Regular maintenance audits relating to fire safety records, legionella, legionella, maintenance of safety equipment, gas safety, boilers, call systems, portable appliance testing (PAT) were undertaken. Where actions were required they are taken forward within a reasonable timescale.

People and a visitor told us the provider provided a safe environment. Comments included; "I feel absolutely safe here. I walk about, wash myself (except for my back). I have my own bit of garden too "; "I feel safe and secure here"; "He is safe here. He is a lot better than he was"; and "I think it's brilliant. He couldn't be looked after better."

Requires Improvement

Is the service effective?

Our findings

People's rights were not consistently upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In people's care plans we saw information about their mental capacity and that Deprivation of Liberty Safeguards (DoLS) were being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

Consent to care was not always sought in line with legislation and guidance because the principles of the MCA had not always been followed. This was particularly in relation to the use of bed rails and sensor mats. Some people had bed rails in place, but it was not clear from the documentation in place whether any less restrictive ways of keeping people safe had been considered. People's capacity to consent to the use of bed rails had not always been assessed. For example, we looked at the plan for one person with bed rails. Staff had documented "Is quite happy for husband to make decisions for her due to her dementia and decline in cognition". There was no capacity assessment in place for the use of the bed rails and although the person's husband had signed the "Safe use of bedrails" form there was nothing in place to indicate that a best interest decision had been considered before using the rails.

Another person also had bed rails in place. In their sleep plan it had been documented "Likes to have two pillows and bedrails." In their cognition plan it had been documented "mental state appears to be impaired" and "has mental capacity and can at times make sound decisions regarding her care", but there was no capacity assessment in place for the use of bedrails. Additionally, although the safe use of bedrails form had been signed by staff, it had not been signed by the person or their representative.

Some people had been assessed as being at risk of falls and had sensor mats in place. Although the sensor mats were being used as an aid to keep people safe, there was no evidence that relevant persons had been consulted as to whether this was in the person's best interests and the least restrictive option

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

Staff had received MCA training. We observed staff always asking people to agree and consent before care or assistance given. They used phrases such as; "Would you like me to...?"; "Is it alright if....?"; and "Where would you like to sit ..?"

New staff undertook an induction and a provider prescribed mandatory training programme before starting to care for people on their own. Staff told us about the training they had received; this covered a variety of subjects such as moving and handling, infection control, understanding dementia and CPR. The training records demonstrated that staff mandatory training was in the main up to date, Where training required updating courses had been booked. The majority of people told us they were satisfied that all their needs were being met by staff who were knowledgeable and had received the necessary training. Comments

included; "They are confident and knowledgeable. The older ones are the most experienced"; "Really smashing staff. No trouble with any of them"; and "Staff are very good."

Staff were consistently supported through a regular supervision programme. Supervision is where staff meet one to one with their line manager. Staff comments included; "I think it's every two or three months, but it's very regular" and "I'm booked for one tomorrow."

People's nutrition and hydration needs were met. People's nutritional needs were assessed and where risks were identified, specialist support was sought. Records showed that people had been reviewed by the speech and language team (SALT) when swallowing difficulties were identified by staff. Care plans had been updated to reflect the recommended guidance. For example, the plans detailed the texture of food that people should be offered and the position they needed to be in when eating. Plans guided staff how best to support people to have enough to eat and drink. For example, in one person's plan staff had documented the person's food preferences. The person was losing weight, but staff had noted the person ate more when in the dining room eating with other people. The plan guided staff to encourage the person to eat their meals with others. We observed the person eating their meal with others.

People's weights were monitored. One person was overweight and records showed that staff had sought dietician support to help them lose weight. When people had lost weight, GP advice was sought and we saw that some people had been prescribed supplements.

People were offered regular drinks. Some people were having their food and fluid intake monitored. Target fluid intakes were recorded and the charts that we looked at had been completed in full and showed that people had enough to eat and drink. When people's fluid intake was less than the recommended target, records showed that this was identified and communicated to the rest of the team to address and take forward. We received a number of positive comments about the food. Comments included; "The food is lovely "; "The food is hot when it arrives. They ask in the morning what I want. If I don't like it I have ham egg and chips. I don't actually see the menu at all. There are plenty of drinks but I miss a hot drink at lunchtime – they've stopped that"; and "The food is good here, you get a choice."

People had access to on-going healthcare when required. Records showed that people were reviewed by the GP, dietician, and the tissue viability nurse.

Requires Improvement

Is the service caring?

Our findings

The observed dining experience was mixed. In Ash Way, people had chosen what they wanted from the menu earlier that morning. Tables were well presented and attractive. Linen cloths, napkins, metal cutlery, condiments and flowers were placed on every table. People were all offered personal protective equipment, such as cloth bibs. All ate independently apart from two people who were assisted. Staff maintained eye contact, explained what the food was, and encouraged people to eat. People were also encouraged to eat independently by staff. Staff advised people what was on their plates when serving. Service was very efficient and no-one had to wait for their food.

The dining experience of those people living on Mendip View and Beech Walk, where people were living with dementia, was not delivered in a way that was wholly person-centred. People were shown the options of food available and alternatives were provided, when requested. We noted that at meal times, a number of people required supervision and support with their food. On Mendip View, there were two staff responsible for supporting those people who required assistance to eat. Meals were often placed in front of people with little or no interaction. For example during our observation, we saw staff members supporting people with their meals; there was little eye contact and little or no interaction with people. We also noted that one person left unsupported, fell asleep in both their main meal and their dessert. We observed the same person falling asleep in their meal on both days of our inspection. On the second day, staff roused them occasionally. However, they were face down on the table and had their hair in their pudding for nearly 15 minutes until the chef came in from the kitchen and said "Is she alright there?" Although we observed a number of positive interactions staff were unable to give time and attention to people. It was a task orientated experience and not a relaxing experience for people.

People's dignity was in the main respected. Comments from staff included "I always close the door and the curtains. We have signs to put on doors too". We saw that staff put signs on people's bedroom doors during personal care to inform others not to enter. One member of staff said "I give people a choice of a bath or a shower every day. I ask them what they want to wear. The ladies might like a bit of lipstick so I offer that too". One person felt that there had been an occasion when her privacy and dignity had not been respected. They told us; "Agency staff don't always respect your privacy and dignity. [Staff member's name] and another agency worker tried to get me up too early. They burst in. The agency worker stood in the doorway watching me whilst I was using the toilet. I did not like this." We observed an incident in the dining room where privacy and dignity not observed. One person requested to go to the toilet after lunch. A staff member stated; "Do you want to help me take [person's name] to the toilet?" This was said in front of everyone in the dining area.

Advanced care plans had not always been completed in full. We saw there were gaps in some forms. Staff had written on other forms that people's families had not wanted to discuss plans for the future and this decision was respected. We looked at the plan for one person who staff said was nearing the end of their life. The plan had not been amended to reflect this. For example, the person was having very little to eat or drink, and when we saw them their mouth was visibly dry, but their personal care plan guided staff to provide mouth care twice a day when they clearly needed it more frequently. In this person's pain care plan it had been documented "Not able to tell staff if experiencing pain" and "has no prescribed medication for pain

relief. If experiences pain, we will ask GP to review". There was nothing documented to inform staff how to recognise if the person was in pain. Additionally, although the person had been reviewed by the GP two days earlier staff had not requested for pain relief to be prescribed in case needed . We discussed this with the deputy manager. They advised that the provider had an end of life template care plan which they would put in place for this person and would ask the GP to prescribe pain relief.

People and their relatives felt that the staff were caring. Comments included; "Some are more natural carers than other, but largely yes they are caring"; "I'm quite happy with everything"; " They're looking after me alright"; "Several staff are jokers and we have a good laugh"; " They are very caring- the regular staff are very caring towards her "

Staff spoke highly of the care they provided. Comments included; "The staff have great relationships with residents. I love working here", "All of the staff here are committed, they really do care. For example, a housekeeper might spot someone needs help and will come and ask us to help them"; "People do get really good care here. I always make sure people have clean finger nails and that people have plenty to drink". Despite their reservations regarding the current staffing levels all of the staff we spoke with said they would recommend the service. Comments included "I would absolutely recommend it here. The staff are caring and well trained" and "I would recommend it. I love working here."

All residents looked well cared for with clean clothes, hair and fingernails. They were all smartly and appropriately dressed. Staff looked after people's possessions and belongings when they were moving about, such as their glasses and handbags. We observed in the majority of cases that staff interacted with people in a friendly and caring manner. Staff appeared to know people well and used their first names. Staff knew people well and were able to tell us about their likes and dislikes and about their family backgrounds.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection people were not fully protected against the risk of unsafe or inappropriate treatment as records were not properly maintained. The service did not consistently deliver appropriate care that met people's needs. Improvements had been made but this area of their work requires further development.

When people were assessed as being at risk of pressure sores, the plans detailed how staff should minimise the risk. The plans included details of any pressure relieving aids, such as air mattresses, and pressure cushions. When people needed to have their positions changed regularly, position change charts had been completed in full and showed that people had their positions changed in accordance with the care plan. We found an exception in one care plan. It stated that the person was immobile in bed and needed staff support to be repositioned throughout the night to prevent pressure areas. We looked at the relevant repositioning chart. Their requirements were not written on their chart or in the care plan. When we asked the nurse in charge about this, they stated that it should be four hourly. We looked at the chart for the previous night and the person was not re-positioned in accordance with the person's needs.

Wound care plans were clear and contained photographs of wounds so that staff could easily observe for signs of improvement or deterioration. When required, advice had been sought from tissue viability nurses.

Plans detailed people's care in relation to their medical needs. For example, we looked at the plan for one person with a supra pubic catheter. The plan included the signs and symptoms of an infection to observe for and how to care for the catheter.

Sections of care plans we looked at were person centred but this was not seen consistently throughout all of the plans. For example, life history documents had not always been completed in full which meant it was not always possible to understand about people's lives before moving to the service. Although not documented it was evident when speaking to staff they had an understanding of people's backgrounds. Other sections of plans were person centred, for example, personal hygiene plans detailed people's preferences for baths or showers, and the clothes they liked to wear. Staff said "If people want a bath every day, that's what they have. It's their choice." Where possible, people using the service and their advocates were involved in care plan reviews. Copies of letters that had been sent to relatives inviting them to attend.

There is a full weekly social activity programme and this is displayed in the corridors and people were provided with a copy in their rooms. Staff reminded people and asked if they wish to participate. Morning and afternoon sessions were held on different floors on the Ash Way and Salisbury Rise. People were moved between units to attend what sessions they wanted. The activity coordinators were visible and went to great lengths to try and persuade people to join in. Some people chose not to participate and this was respected. We were shown the "Activity Evaluation Plan "for the communal activities provided throughout the service. These were recorded daily and kept in files for evaluation. People requiring one-to-one activities on Ash Way and Salisbury Rise were also recorded in this file. We were told by the activities coordinator that people on this list should receive one session per week. We saw no evidence recorded that people on Beech Walk and

Mendip View were receiving one-to-one time. The deputy manager told us they went to see people in their rooms each day and the activity co-ordinators tried to see people.

Comments regarding the activities included; "There should be more time spent one-to-one. Other people would like more company"; "I get on well with the hairdresser. She is interested in you as a person. We get on fine and it's lovely to be able to have a proper conversation"; "I have my own bit of garden that I look after. I have put all the flowers in it and the bird feeders. It is very pleasant in the afternoon. Being out in the garden does me more good than all the pom-pom waving in the world"; "I enjoy the trips out. We went to the Garden Centre. I go to the hairdressers in my wheelchair"; and "There's one staff member who will come and take me out downstairs in the garden. Once a week we get the choir, I like that."

Relatives were welcomed to the service and could visit people at times that were convenient to them. There were facilities for family members to make drinks for themselves. People maintained contact with their family and were therefore not isolated from those people closest to them.

The provider had a protocol in place to receive and monitor any complaints that were made. No formal complaints had been received since our previous inspection. People knew how to raise a complaint and felt they would be listened to. Comments included; "I've no complaints. I'm happy with how things are"; "No complaints at all"; "The family made a (informal) complaint a few weeks ago but it has been sorted. It was about the time taken to take them to the toilet."

Inadequate

Is the service well-led?

Our findings

At our previous inspection we found the provider did not have effective governance systems in place to monitor the completion and accuracy of people's care records. We found some improvements had been made on this area of their work, however these were not effective in driving all the improvements needed in significant aspects of the service. Since July 2013 we have conducted a comprehensive inspection at the service six times. The provider has failed to fully meet all the regulations at each inspection. Since the previous inspection in March 2017 there have also been repeated breaches of the same regulations. These relate to staffing and failing to submit statutory notifications. We have also identified additional concerns relating to recruitment checks, good governance, safeguarding adults and consent. The provider did not consistently have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. The audit systems had not identified that the continued breaches of the regulations had failed to be sufficiently rectified. The systems in place did not identify all the shortfalls found at this inspection. Following the previous inspection in March 2017 the provider has been sending monthly reports regarding staffing, risk assessments and room checks. They have failed to identify and sufficiently address the issue regarding staffing levels and the support required.

We did note that the provider's Regulation Team audit conducted on 23 August 2017 was detailed and had identified some similar concerns to those found at this inspection. These included: an incident that had not been referred to, or advice sought from the local authority safeguarding adults team; during the mealtime service some people were not supported in a timely or person-centred manner; and dignity was not always upheld. One of their observations identified; "One lady was observed sitting in the same position at a table from breakfast time until lunch time. Staff did not appear to provide any interaction and at times were not present in the room. The person dozed for long periods but staff did not transfer her from her wheelchair to a more comfortable chair of encourage her to participate or watch the activities in another room." The issues identified had yet to be sufficiently resolved by the service. The audit identified that there had been a complete audit of all care plans over recent months and on-going audits. Action plans had been written as a result of the care plan audits by the previous registered manager and deputy manager. However, the deputy manager told us that they were aware that some of the required actions had yet to be completed by the nurses on the floor . The deputy manager advised that improvements had been made but further work was required regarding compliance with their action plans. It was still work in progress. We also noted that improvements had been made and they were nearing completion of this area of their work. Some further work was required on end of life care planning and life history documentation. Advanced care plans and life histories had not always been completed in full.

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

At our previous inspection we found that the provider had failed to notify the Commission about certain changes, events and incidents affecting their service of the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled to ensure the safety and welfare of people. The service had failed to make

appropriate safeguarding adults and serious incident notifications to the Commission, as required. These included unexplained bruising, a scalding incident, unexplained skin tears and alleged abuse against a person. Following the inspection the deputy manager wrote to us to advise that nurses and heads of unit had received information regarding statutory notifications through their 'webinar'. They told us that the matter would also be discussed in a larger forum during the registered nurse meeting being held on the 16 October.

There is a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff felt well-supported by the deputy manager. Comments included; "The deputy manager is our go to person"; "The deputy manager is very supportive and approachable." Staff felt unsettled by the recent departure of the registered manager and did not feel fully informed. Comments included; "The acting manager just showed up. She didn't introduce herself and there was no staff meeting to let us know what was happening"; "The new manager turned up, but we didn't know anything about it. She didn't come and introduce herself"; "I asked who she (the acting manager) was and she said she was the manager. I had no idea the old manager had left." Despite this feedback the majority of staff told us that staff morale was "better" and "improving." Staff felt things were changing and improvements were being made. Staff told us; "Things are changing in a good way"; "Our paperwork is much better, we're trying our best to get better"; and "Things have got better, we've got more paperwork in place now."

The deputy manager held a regular programme of staff meetings to advise them of operational and clinical issues which required actions. This line of communication has resulted in improved recording, particularly regarding risk management. The staff meeting chaired by the previous registered manager held on the 10 August raised concerns on the staffing levels and the DICE dependency tool. The previous registered manager informed the staff; "I already told everyone at Barchester that we don't have enough staff." Following the inspection the deputy manager advised that they will conduct a trial period where the service will be staggering the meal service on each of its four units to ensure each resident has a good experience during their mealtime. They will ensure all staff on duty are free to assist those people who are currently cared for in their rooms and require assistance.

To enable people to provide feedback on their experience of the service resident meetings were held. The most recent meeting was held on 10 June 2017. Activities, food and staffing were discussed. The previous registered manager agreed to take forward actions regarding the purchase of new board games and ensuring fish is provided every week for people on soft diets. One person commented on the staffing. They commented; "There are not enough staff and too many change overs, also not all the staff are of the same calibre, I understand it's an impossible task." The registered manager advised the meeting that the provider is really good with training and stated; "We never leave two members of staff on the unit, we utilise staff from other units, however this rarely happens as we do our very best to cover shifts." The provider has also recently sent a questionnaire to people and their representatives seeking their views on a number of issues relating to the service and the care provided . Comments from people and their relatives about the management of the service included; "There have been a few ups and downs. It's not an easy job running a place like this"; "You need continuity in a place like this"; "The manager will often speak. She is approachable"; and "I would recommend it here."