Haydn-Barlow Care Limited

# Holmfield Nursing Home

## Inspection report

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Date of inspection visit:
16 May 2017
17 May 2017

Date of publication:
07 July 2017

## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The inspection took place on 16 and 17 May 2017. The visit was unannounced on 16 May 2017 and carried out by two inspectors. We informed the provider that one inspector would return on 17 May 2017 to complete the inspection.

Holmfield nursing home provides accommodation, nursing and personal care and support for up to 22 older people living with physical frailty due to older age and complex health conditions. At the time of the inspection 13 people lived at the home. The home has two floors; with a communal lounge and dining area on the ground floor.

The home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. At the time of this inspection the home had a registered manager in post, who had registered with us in March 2016.

When we inspected Holmfield Nursing Home in August 2016, we gave a rating of 'requires improvement.' In November 2016, we returned to undertake a focused inspection which looked at whether the service was safe and well led. This was because we had received some information of concern regarding the management of risks to people's safety and wellbeing. At our focused inspection, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and gave a rating of 'inadequate.' The service was placed in 'Special Measures'. Services in special measures are kept under review and inspected again within six months. In November 2016, the provider agreed to a voluntary placement stop which meant until improvements were made, no new people would be admitted to the service. Following the implementation of some improvements, the provider has maintained a restricted admissions policy. We requested that the provider send us fortnightly action plans on the implementation of their improvements, which they have.

At this inspection we found sufficient improvements had been made to remove the service from special measures. However, we found continued breaches of the regulations that related to people's safe care and in the governance of the home. Some of the provider's planned improvements had not always been made or sustained. Risks of harm to people were identified, however, actions to minimise those risks were not always effective. This was because the governance of the home had not always ensured actions were taken to ensure identified risks to people's safety and wellbeing were managed effectively.

Staff did not consistently feel supported by the registered manager or that concerns raised were acted on. Audit systems and processes to monitor the quality and safety of the service were not always effective in identifying where improvement was needed. The governance of the home was not always effective in protecting people's safety and wellbeing and staff did not consistency feel supported by management.

The provider's improvement plan for the clinical support of the registered manager had been further delayed due to staffing changes. This also meant some planned improvements had not yet taken place. This included the support of nursing staff and undertaking their clinical competency assessments.

People had their prescribed medicines available to them and, overall, people were given their medicines by nurses following safe practices. However, we found records of some medicine applications were not kept by nurses to ensure manufacturer's instructions were followed.

Staff knew how to deal with emergencies that might arise from time to time. The provider had a safe system of recruiting staff and checks were undertaken to make sure staff were of good character before they supported people who lived at the home. However, further checks to update records for long standing staff were not undertaken to ensure staff remained of good character.

Staff were given training and care staff felt this gave them the skills they needed for their role. However, nurses felt they were not offered sufficient opportunities to update and refresh their clinical skills. Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Overall, people enjoyed their food and were supported when needed with their meals and drinks. However, staff told us food choices were occasionally restricted because they ran out of basic items, such as white bread. People were supported to maintain their health and access healthcare professionals, although referrals were not always made as soon as they could have been.

Most people felt staff were kind and had a caring approach toward them. People told us staff did their best and overall, responded to them as quickly as they could. People were able to summon staff attention if they were in their bedrooms but improvement had not been made to ensure people had a call bell accessible to them in the communal lounge, that was not consistently staffed, and meant people could not gain staff attention if needed. Staff felt they were restricted in how far they were able to personalise care to individuals because of time constraints and felt care continued to be task led. Staffs were not consistently respectful to people when they focused on non-care tasks.

There were very limited opportunities for people to take part in any group activities or be supported with individual hobbies or interests so that risks of social isolation were minimised. People and their relatives felt activities had become less in the home and felt more were needed.

The provider's complaints policy was displayed and relatives felt they could raise issues if they needed to.

We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Requires Improvement'

You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Risks of harm to people were identified, however, actions to minimise those risks were not always effective because the provider's staffing levels did not allow staff to consistently implement actions to minimise identified risks.

People had their prescribed medicines available to them. Records of some medicine applications were not kept as needed.

Staff knew how to deal with emergencies that might arise from time to time. The provider had a safe system of recruiting staff and checks were undertaken to make sure staff were of good character before they supported people who lived at the home.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Nurses felt they were not offered sufficient opportunities to update and refresh their clinical skills. Care staff had undertaken training to deliver care and support, which they felt met their needs.

Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Overall, people enjoyed their food though staff told us they ran out of basic items at times which restricted choices people had. People were not consistently offered snacks, such as high calorie snacks, as they needed.

People were supported to maintain their health and were referred to health professionals. However, referrals were not always made as soon as they could have been.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People's privacy and dignity was promoted by care staff. However, staff did not consistently demonstrate a respectful approach toward people when undertaking tasks.

Most people and their relatives told us that staff were kind and caring towards them. Staff supported people to be involved in decisions about their care, such as where they spent their time.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People felt staff attended to them as soon as possible and did their best. Staff felt they were restricted in how far they were able to personalise care to individuals because of time and felt care continued to be task led.

There were very limited opportunities for people to take part in any group activities or be supported with individual hobbies or interests so that risks of social isolation was minimised.

Relatives told us they knew how to make a complaint if needed.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

The provider's systems and processes to monitor the safety and quality of the service did not always identify where improvements were needed. The provider had not always ensured actions where risks to people's safety and wellbeing were identified were managed effectively.

Staff did not consistently feel supported in their role by the registered manager. The provider's improvement plan for the clinical support of the registered manager had been delayed due to a change in the clinical lead nurse.

# Holmfield Nursing Home

**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.

The inspection took place on 16 and 17 May 2017. The visit was unannounced on 16 May 2017 and the inspection team consisted of two inspectors. We informed the registered manager and provider that one inspector would return to complete the inspection on 17 May 2017.

The provider had previously completed a provider information return (PIR). 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. Prior to this inspection, a request for a new PIR was not made. Since our last inspection in November 2016, the provider had sent us fortnightly action plans telling us about the improvements they had made. During this inspection, we gave the registered manager and provider an opportunity to supply us with information, which we then took into account during our inspection visit.

We reviewed the information we held about the service. This included information shared with us by the local authority and notifications received from the provider about, for example, safeguarding alerts. A notification is information about important events which the provider is required to send us by law. The registered manager had informed us about some incidents that we followed up on during our inspection.

We spent time with people and saw how they received care and support. This helped us understand their experience of living at the home. We used the Short observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
We spoke with eight people and spent time engaging with people who lived at the home. We spoke with three relatives who told us about their experiences of using the service. We spoke with staff on duty including eight care staff, three nurses, one cook, the clinical lead nurse and the registered manager. We also spoke with the owner of the home, who we refer to in our report as the provider. We spent time with and observed care staff offering care and support in communal areas of the home.

We reviewed a range of records, these included care records for five people, people's food and drink charts, one person's wound and pressure area management plan and nine people's medicine administration records and three staff employment files. We looked quality assurance audits and feedback from people.

We left a poster about our inspection, displayed at the home which told relatives how to contact us to give us feedback if they wished to.

Requires Improvement

# Is the service safe?

## Our findings

At our focused inspection in November 2016, we identified that whilst risks associated with people's care were assessed, actions were not always put into place to reduce the risk of harm. People were not consistently protected from the risks of abuse and the provider's staffing levels were not sufficient. Staff did not always have equipment they needed, such as foot rests, to ensure people were comfortable and that identified risks, such as their skin becoming sore or damaged, were reduced. We rated this key question as 'inadequate' and asked the provider to send us fortnightly action plans on how improvements would be made, which they did. At this inspection we found some improvements had been made, however, some risks to people's safe care and treatment had not been effectively managed by the registered manager or provider.

At our last inspection, we saw that a person whose risk assessment stated 'not to be left alone' in the communal lounge areas, was left unobserved by staff. Staff told us this was because there were insufficient numbers of them to enable one staff member to remain in the communal lounge. Since our last inspection, the registered manager had informed us of further incidents involving this person. Whilst the registered manager and provider had sought guidance from external agencies, they had informed the local authority that they were managing the risks presented to ladies who lived there. On this inspection, we identified the risk posed was not effectively managed.

People did not consistently feel protected from abuse because of the risks posed to them by another person who lived there. One person warned us, "You have to be careful with (pointing to one person)." Staff told us they had completed training on how to safeguard people from abuse and would report concerns to the registered manager. One staff member told us, "Staff here feel frustrated because we can't always protect people because we don't have the staffing numbers for one of us to stay in the lounge. The manager knows we can't always be in the lounge."

On previous inspections, in January 2016 and August 2016, we identified to the registered manager and provider that people in the communal lounge could not gain staff attention if they needed to, because they did not have an accessible call bell. At this inspection, the previously broken call bell point in the lounge had been repaired and a call bell cord was attached. However, this was left looped resting on the back of one armchair and was therefore not accessible to people. Whilst improvement had been made to ensure the call bell worked and a cord was attached, people could not access it.

We identified some areas relating to the management of medicines that were not safe. Special forms for 'when required' medicine had incorrectly been used for people who were prescribed insulin injections twice every day. The incorrect use of the form posed a potential risk of staff, such as agency nurses, being confused and not administering the insulin as prescribed.

A nurse told us one person had their medicines crushed and dispersed in water. Whilst this person's hospital discharge information stated this was to enable them to safely swallow their medicine and most of their medicine pharmacy labels instructed to 'crush and disperse', we found no further information had been

recorded by the provider to ensure a consistent approach was taken by nursing staff at the home. We asked the nurse how they knew whether all the tablets could be crushed together or not and how much water they should use. This nurse was not able to show us any guidance and told us, "Each nurse uses their own judgement."

Some people were prescribed medicines known as controlled drugs with specific legal requirements. These were stored safely and available to people as prescribed. However, we found nurses were unaware of the manufacturer's instructions that related to three people's pain relieving skin patches and how these should be safely applied on to their skin. For example, the manufacturer's instruction stated the same skin site should not be re-used for a new patch for three to four weeks. Nurses kept no record of where patches were applied so could not be assured they were following the manufacturer's instructions for use.

Communication between nurses was not always effective and meant referrals to GPs were not always timely which posed a risk to people's safety and wellbeing. For example, at 7pm on 10 May 2017, one nurse recorded that care staff had reported a health concern about one person and on this person's 'next turn' (reposition) due at 9pm, the nurse on shift should 'examine.' We found no record of the nurse undertaking this check and the same health care concern was recorded on 11 May but there was no evidence of any action being taken until 12 May when a nurse contacted this person's GP.

When people were prescribed new medicines, we found these were not always commenced in a timely way. One nurse told us, "We often have to wait a few days for the pharmacy to deliver, I once told the manager it would be much better if someone could collect new prescriptions from the surgery and take it to the pharmacy and collect the medicines needed, but nothing changed." Minutes from a previous staff meeting had identified delays in new prescription medicines being received but we found no action had been taken to address this with the pharmacy or make alternative arrangements for collecting urgent new medicines. We discussed medicine delivery with the registered manager who agreed there were occasional delays but said they did not have anyone available to collect prescriptions and new medicines. We saw one person's GP had prescribed a new medicine for them on 12 May 2017 and this was delivered to the home on 16 May. This person told us, "I'm in pain." Following our inspection, we discussed this with our pharmacy inspector who told us the delay in the specific medicine being commenced for the diagnosed health problem meant the person may potentially have been in discomfort longer than needed. The prescribed medicine should have been commenced as early as possible following the GP prescribing it.

When we returned for our second inspection day, we asked the nurse whether this person had now been given their new medicine, but the nurse told us they did not know anything about it. We found poor communication between nursing staff had led to a further delay in two people being administered their new medicines. Medicines received on 16 May 2017 had not been checked or booked in by the nurse on shift and important information had not been communicated during shift 'hand over' or recorded on the 'hand over' record. Following us discussing this with the nurse, they ensured the new medicines were recorded and given as prescribed.

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

We looked at the provider's systems for the safe management of medicines. We looked at five people's medicine administration records (MARs) and found that, overall, these had been completed accurately to show people had received their medicines as prescribed. We observed one nurse administering medicines to people in a supportive way; they explained what the medicine was and offered a drink to people to help them swallow their medicines. Care staff told us they applied people's prescribed topical preparations, such

as creams, when needed. We saw people had a 'body map' form which informed care staff where cream needed to be applied to a person's skin and records of application had been completed by care staff.

We looked at staffing levels on shifts and how people's needs were met. We found there was not consistently sufficient numbers staff available to safely meet people's needs. Staff told us there were shifts when they were short of care staff, one staff member said, "Often we have one nurse and two carers, it's not enough."

The registered manager showed us their dependency assessment tool they used to determine staffing levels. They told us they planned to have one nurse and three care staff on daytime shifts and one nurse and one care staff on night time shifts. The registered manager added that agency nurses were, on occasions, used when needed. We saw the provider's dependency tool focused on physical tasks people required support with and did not take into account individual's holistic needs that included how they spent their time for their emotional wellbeing. We discussed staffing levels with the owner of the home, who told us that despite lower occupancy levels, they had not reduced staffing and believed staffing levels were sufficient to meet people's needs.

During our last inspection, we found risks to people's skin becoming sore or damaged were assessed. However, actions were not always taken by staff, to appropriately prevent skin damage from occurring, and care records about people's skin were not always accurate. The registered manager and provider told us action would be taken to improve nurse's performance and they would ensure all nurses would attend tissue viability (skin care) training by the end of March 2017. At this inspection we found only one of the nurses had attended the training and the remaining six nurses were scheduled for a date in June 2017. The registered manager told us this was due to a March training date being cancelled by the local hospital and nurses had not been available to attend earlier dates offered. However, one nurse told us they had only been offered the June 2017 date, which meant planned improvements had not taken place a timely way following concerns identified to them at our November 2016 inspection visit.

Whilst improvements had been made to the design and format of care records available to nurses for the management of skin damage, further improvements were required to ensure nurses consistently used them. For example, one person identified at 'very high risk' of skin damage had an entry in their care notes that recorded a dressing had been applied to a 'reddened area' on their skin. However, we found there was no care plan, no skin damage record and no photograph of the area. The clinical lead nurse agreed that nurses were using the forms for 'graded pressure sores' but added, "I agree we need to record any skin damage on the forms, have a care plan in place about the frequency of dressing changes and take photographs so we can assess the progress or deterioration of skin damage."

Risk assessments in place to reduce risks of damage to people's skin directed staff to check that special equipment, such as airflow pressure relieving mattresses, were on the correct setting for people. However, staff, when asked, did not know what settings pressure relieving equipment for each individual should be on because there was no information available in people's care plans to inform them. The newly appointed clinical lead nurse told us they would ensure staff had the information to check pumps for airflow mattresses were set according to a person's body weight.

Some risks to people that had been identified by staff to the registered manager, were not addressed in a timely way. For example, the flooring of two people's shared en-suite was not level and was damaged. One staff member told us the issue had been reported and said the toilet leaked, they added, "The leak gets patched up but it doesn't seem that a proper job is done as the leak comes back, and the flooring has not been replaced." Another staff member said, "The floor has been a risk to people falling or tripping for about a year, it's been reported but nothing has been done." We showed the damaged flooring to the owner of the

home and they told us, "I'll get that sorted out urgently and ensure the leak has been dealt with."

Other risks to people were assessed and, overall, actions were put into place to reduce the risk of harm and injury. For example, one person had a bedside 'grab rail' which they told us was 'helpful' to steady them when they moved to sit on the edge of their bed. We saw staff used safe moving and handling techniques when using a hoist to transfer people from their wheelchair to an armchair and offered reassurance to the person, explaining to them what was happening. However, care staff told us they had not been taught a 'log roll' moving technique as a part of their safe moving and handling training. We saw one person needed this technique as their safe way to be moved in their bed. The clinical lead agreed more information was needed in this person's risk assessment so staff had the details of how to safely 'log roll' this person to prevent harm to them from an existing injury.

Most staff knew how to record accidents and incidents. However, during our inspection we were made aware of an incident that had occurred over the past weekend, but no incident report had been made by the nurse and the registered manager had not been made aware. The nurse told us they had forgotten to record the incident or tell the registered manager.

The provider had suitable arrangements in place to deal with emergencies that might arise from time to time. For example, people had personal emergency evacuation plan (PEEPs) and emergency evacuation equipment was available for staff to use if needed.

The clinical lead nurse informed us they were the first aid qualified staff member on shift. We gave them some first aid scenarios such as a person choking and they described the safe first aid action they would take. The provider told us they had sufficient first aid qualified staff to ensure one such staff skilled staff member was on every shift.

The provider's recruitment practice ensured risks to people's safety were minimised. One staff member said, "I started working here about four months ago, but I had to wait until the manager had received my references and DBS check." Of the three staff files looked at, all showed that a check had been completed with the Disclosure and Barring Service (DBS) to ensure staff were of good character and suitable to work at the home.

The registered manager told us they had used agency nursing staff on a regular basis to cover their own nurses' leave. The registered manager said, "We've had some nurses off work, so have had different agency nurses working here." An 'agency staff file' was kept and we were told at our last inspection improvements would be made to ensure worker's information and 'profiles' were available. Worker's profiles listed training and the clinical details for nurses. We asked to look at the 'profile' for the agency nurse that had worked the past weekend shift at the home, however, the registered manager could not locate this or the worker's induction check list. The operations manager confirmed they did not have an electronic copy of the profile we requested. The registered manager concluded they did not the information and there was no evidence of an induction being carried out into important information about the home. The registered manager told us, "The file still needs doing; I'm not sure who was meant to be doing that."

We looked at the cleanliness of the home and the provider's systems for infection prevention and control. Some relatives told us they felt the home was 'dirty.' One nurse told us they felt there should be a cleaner on every shift. They added that a few relatives had complained to them about the lack of cleanliness, which we saw had not been recorded in the complaints log. The nurse told us they felt they had dealt with the issue by taking one staff member off caring duties to undertake cleaning tasks. We discussed this with the registered manager, who told us they had one cleaner but had advertised for a further cleaner to fill a vacancy.

We found some areas of the home were worn, such as the dining room flooring where wooden laminate was cracked and broken in places, which meant effective cleaning could not take place. One person's wheelchair had dried food debris on the seat area and this person told us, "Staff don't offer to clean it for me." On both days of our inspection, we saw tea towels on the floor in the kitchen and one staff member told us, "They are put there because the fridge leaks." This posed potential risks of cross infection as tea towels were also in use on kitchen surfaces.

Requires Improvement

# Is the service effective?

## Our findings

We last inspected how effective the home was during our inspection in August 2016 and gave a rating of 'good'. However, at this inspection we found the effectiveness of the service had not been sustained and some improvements were needed.

One nurse told us, "I feel the management is very poor here and I feel unsupported in my role. When I have mentioned this to the manager, they just told me they are not a nurse and I've had no clinical support from the clinical lead nurse, the new one has only just started working here." They added, "Over the past two years, I've had hardly any training here, only the on-line basic sessions and no real clinical training at all. I feel out of date." Another nurse told us they felt they had the skills they needed for their role despite not having completed any recent skill refreshing updates. A further nurse told us they felt some of their fellow nurse's skills needed to be updated to ensure people were safe and effectively cared for; following best practice.

Whilst nurses did not feel their training met their needs, care staff felt training had improved since our last inspection. Most staff we spoke with had worked at the home for several years, however, one member of staff told us, "I started working here this year, I had an induction when I was shown around and have completed some online training, and I think I have some other sessions still to do. The other staff have been helpful to me, showing me what to do. I'm enjoying my job here." Care staff felt satisfied with the training they received, one member of staff told us, "Since the last CQC inspection, I think some of our training has improved. It is no longer all on-line, but we have some taught face to face sessions now which are much better." Another member of staff said, "I am doing my level three (social care diploma) at the moment. The provider has supported this, the training has got better."

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

Whilst staff told us they felt they would benefit from an update on the MCA to refresh their knowledge, we saw they worked within the principles of the Act. Staff understood the importance of explaining what was happening to people, such as when the hoist was being used to transfer them, and told us they would not force people to do anything they did not wish to do. One member of staff told us, "We have to try our best to follow people's choices but in their best interests." Another said member of staff said, "Some people can make decisions but some cannot. Some people struggle to communicate, so we look at their body language, we get to know people. For a big decision, that someone did not understand, I would go to the management to raise it."

The registered manager told us they understood their responsibilities under the Act and gave us examples of when they would refer a person for a 'best interests' meeting. They added that two people who lived there had DOLs in place and they had made a referral to the local authority for another person.

We looked at whether people's nutritional and hydration needs were met and asked people what they thought about their meals. Overall, people said they enjoyed their meals and felt they had enough to eat and drink, one person told us, "I had a lovely cooked egg sandwich for breakfast today; delicious." People did not know what choices were on the menu, however, one person told us, "I let the staff decide what I have, they know what I like."

The cook informed us they followed a rolling four weekly lunchtime menu and added if people did not like something they could have an alternative such as a 'cold meat salad.' The cook had access to information detailing anyone who had specific dietary requirements and told they worked from this information. However, one person's food consistency was described as needing to be 'fork mash able' but we saw their 'likes' listed crackers with cheese which was not fork mash-able and may, if given, be a potential risk to their wellbeing. The clinical lead nurse told us they would ensure the information was checked so that staff had the correct details.

One person commented to us about their teatime meal and told us, "It is meat sandwiches or meat sandwiches." Care staff told us they felt the teatime meal they prepared for people was limited and lacked choices. One staff member said, "I open the cupboards and struggle to find any choice to offer people." Another staff member said, "It is mainly sandwiches and crisps every day and there is no real variety." Another staff member told us, "There is never enough. We are always running out of food, like bread and milk. There is no white bread left today and some people don't like brown bread." We saw one person had some soup which they told us they enjoyed but preferred white bread.

We discussed what staff had told us about food items that ran out, with the registered manager and provider. The registered manager told us, "Our main shopping delivery is Thursdays, but because we have run out of a few things, we've asked the owner (provider) to place an extra food order which will come tomorrow." On the second day of our inspection, we saw food items were replenished. The provider told us, "It is not acceptable for us to run out of food items. I thought staff had loaves of bread in the freezer, so they always had a stock. I'll ensure items do not run out."

Some people were identified 'at risk' of dehydration and malnutrition. We looked at how staff managed this to ensure people who needed support to eat and drink were provided this in a timely way and that systems were in place to effectively monitor people's intake. We saw staff supported people with their meal or drinks when required.

People had fluid (drink) charts and staff completed these to record when a person had a drink. However, people did not have an individual target amount of fluid and amounts drunk were not totalled each day, which meant opportunities for action when intake was low, were potentially missed. One person's chart for 15 May 2017 recorded drinks had been offered to them between 7.30am to 5pm, we totalled 720mls had been drunk. There was no record of any further drinks being offered to this person. Another person's nutritional care plan stated 'to give lots of prompts with all food and fluids and one carer to assist.' This person's total recorded fluid intake for 15 May 2017, was 340mls. There was no recorded information to indicate any action taken as a result of this very low fluid intake. The registered manager told us nurses were meant to make checks throughout the shift so action could be taken, if needed to prompt and encourage extra intake.

We found that throughout the day opportunities were potentially missed to encourage snacks when food intake had been low. For example, no mid-morning snacks were offered to people and there was limited choice in the afternoon. For example, crisps and biscuits were available but no high calorie snacks for people that needed extra calories due to their low weight. One staff member told us, "The milk is full fat and fortified (extra calories added), there are some yogurts in the fridge I can use if needed, but we don't have any high calorie snacks made for the afternoon tea trolley."

The registered manager told us people's weight was monitored on a weekly basis. However, we identified a few gaps in the weekly planned checks. One person had recently been admitted to the home during April 2017 and there was no record of their arm measurement to monitor their body mass index. The clinical lead nurse told us they believed it had been done but had not been recorded. Upper arm circumference measurements are an alternative way to monitor a person's risk of malnutrition when they cannot be weighed by scales because, for example, they are cared for in bed.

Some people had healthcare conditions such as diabetes that required daily monitoring by nursing staff and records showed this had been completed as required. Staff told us people were supported with optician, dental and chiropody services that came to them at the home. One person told us, "I have my feet done here, I prefer that to having to go out."

Referrals for specialist equipment for people were not always undertaken in a timely way. For example, staff told us they had discussed the need for one person to have some specialist equipment and had asked the registered manager if a referral could be made. One staff member told us, "We asked if [person] could have a specialist commode because the one we use for them is not suitable or safe for them, we've been asking since last year." We discussed this with the registered manager and provider, the provider told us, "I'll certainly look into that." Staff also said the person would prefer to use the dining room to eat their meals, which the person confirmed to us, but was unable to because a suitable wheelchair was not available for them to use. One staff member said, "We've asked for that since last year as well." The new clinical lead nurse told us staff had made them aware of previous requests and this had now been acted on with a referral made to wheelchair services during April 2017.

Requires Improvement

# Is the service caring?

## Our findings

We last inspected how caring the home was during our inspection in August 2016 and gave a rating of 'good'. At this inspection, we found some areas required improvement.

People told us most staff were kind, caring and respectful. One person told us, "I love it here. I have a sing song. I love all the girls (staff)." Another person said, "Yes, the staff are definitely caring. They never say 'no' or 'they haven't got time for me.' They are very conscientious." However, one person commented to us, "Staff are caring, but one or two not quite so much." This person did not wish to expand any further on their comment.

Relatives felt staff had a caring approach toward their family member. One relative told us, "The staff are lovely. They are so pleasant, considering the situations they have to deal with." Another relative commented, "All the staff are pleasant. I have never seen any of them be abrupt of anything, they are really nice to people."

Whenever care staff engaged with people, we observed positive interactions between them. People appeared comfortable and relaxed with care staff and we saw care staff and nurses speak with people, showing kindness and respect. However, we observed that, on numerous occasions throughout the day, staff did not have time to interact and speak with people because they were busy with other tasks. This meant they walked past people, without speaking or acknowledging them. Care staff told us they did not like to walk past people, but as they completed tasks such as heading toward someone's bedroom to support them with personal care, collecting a meal or drink for people in their bedrooms, and taking laundry items to and from rooms, it meant walking past people.

Staff gave us examples of how they involved people in making decisions about their day to day care and support. For example, staff told us they asked people if they wanted to spend time in their bedroom or the communal lounge during the day. People and their relatives were involved in care planning when they moved into the home.

Staff understood the importance of helping people to be as independent as possible. One staff member said, "A lot of people living here need help with everything, but [person] is capable of doing some things themselves, like sitting at the sink and washing their face, so we encourage them to do that."

Staff knew how to maintain people's privacy and dignity. We saw examples of how they did this in practice, for example, by knocking on people's bedroom doors before entering and ensuring doors were closed when people were supported with personal care. One nurse ensured a person was supported to their bedroom when a healthcare professional visited them, so that their privacy was maintained.

Overall, staff treated people in a respectful way. However, this was not consistent; for example, we saw the cleaner vacuumed the communal lounge at 10.00am, and did not speak to or acknowledge people who were sitting in armchairs, as they were vacuumed around them. Tables placed in front of people were

sprayed and cleaned without consideration of the pump spray being close to people's faces. Whilst the task itself was being completed, a caring and respectful approach was not shown toward people. We discussed this with the provider who told us, "The cleaner should not really be vacuuming the lounge at 10.00am when people are there."

People told us their relatives could visit them whenever they wished. Relatives told us they were not aware of any restrictions when they visited, one person's relative told us, "The staff are very welcoming and easy to talk to."

Staff told us they understood the importance of keeping people's personal information private. We saw records, such as care plans, were kept securely and access restricted to those authorised.

Requires Improvement

# Is the service responsive?

## Our findings

We last inspected how responsive the home was during our inspection in August 2016 and gave a rating of 'requires improvement'. At this inspection, we found the clinical lead nurse had started to make some improvements to information in people's care plans. However, other areas that we had identified required improvement, such as the provision of activities, had still not sufficiently improved to meet people's needs.

Staff ensured that people who chose to spend time in their bedrooms had their call bells accessible to them in case they needed to gain staff's attention. Overall, people felt staff did their best and responded to them if they needed support. One person said, "If you shout 'nurse' they come straight away." Another person said, "Staff always ask if you want anything, or they see your bedclothes aren't right, they will sort it for you."

While we were talking with one person, a member of staff came into their bedroom and noticed there was no drink available for them. They returned shortly after to leave a drink with the person." Staff told us they always tried to give their best, but had to tell people they would return to them later if they were busy with another person. One staff member said, "We try to get back to people as soon as we can, but if we only have two carers on (with one nurse), it is harder to meet people's needs when they request support."

Before people moved into the home an initial assessment of people's needs was completed. One relative, who was satisfied with the care their relation received, told us, "My family member recently moved here and the manager went through my relation's care plan with me." An assessment prior to admission, allows the registered manager and provider assess if they can meet people's needs and if required adjust staffing levels and the staff skills.

We saw that despite the lower occupancy level at the home, of the 14 people that lived there, staff told us most people needed a high level of support, for example with personal care tasks. We saw staff were constantly busy meeting people's needs and responded to people as quickly as they were able to. Staff said they gave one hundred per cent to people when they were with them, but this meant other people had to wait. One staff member told us, "This lady would prefer to get up earlier but we were with other people." We saw this person nod in agreement with staff but reassured them, saying, "You are all lovely, don't worry." Another staff member said, (in response to hearing a call bell sounding), "That is [Person's Name], they want to get up. We have explained to them that we will get to them next." One staff member told us, "Generally, I'd say people are up by about 11.00am, but they have already had breakfast."

The clinical lead nurse told us, "I have only recently started working here, but it may be the organisation of the shift needs looking at and also what nurses do as well. I hope to work with the manager and provider to look at this." Care staff told us they felt restricted by the levels of staffing on shift and felt this impacted their abilities to deliver care that was personalised to people's individual needs. One staff member said, "We try to give choices where we can, but we are a bit limited. For example, people now have breakfast in bed, this is so everyone has had breakfast by about 9.30am. People were asked but, to be honest, they didn't really have much choice about it." One person confirmed they were "asked about it" but had no further view on the arrangement. Another person said, "I don't really know if I could choose to have breakfast in the dining

room." The registered manager told us they had spoken with people themselves, during April 2017, to ask if they were happy to have their breakfast in bed. They told us they had also reminded staff that people could change their mind and get up to have breakfast in the dining area if they wished to.

The clinical lead nurse had started to review people's care plans to ensure the information was sufficiently detailed. We reviewed one care record and found improvement had been made to the information available for staff to refer to. The clinical lead nurse said, "It will take some time to go through all the care records and I have only just started on them, but it is my intention to do so and ensure all information is accurate and detailed."

At our last inspection, the provider told us they had recruited a designated activities staff member. People had said that, overall, improvements had been made. However, on this inspection, whilst we saw artwork from activity sessions displayed around the home and people said they enjoyed activities when they happened, opportunities were very limited and some people felt there were very few activities offered to them. For example, one person told us they did not think activities were on offer. They said, "I wish there were more people here at times. It is a bit lonesome." They added, "There is nothing happening today, just eating and watching television; just the usual." Another person in the communal lounge told us, "I just sit here really."

One relative told us they were not aware of activities taking place at the home. They commented to us, "It can be a bit drab. I have never seen any activities or entertainers. I am sure they used to have stuff on but I have not seen any for a bit."

At the inspection, we saw a few people watched a film on the television and one member of staff played dominoes with three people for a short time. Staff confirmed to us that they did not have time to offer other group activities to people or one to one time with people in their bedrooms to prevent social isolation. One staff member told us, "The activities girl is more often than not working a care night shift, or on care in the day. When they do activities, people like it."

We discussed this with the registered manager, who confirmed the designated activities staff member still worked at the home. However, they told us, "The staff member has not been here for the two days of your inspection because they have been doing other shifts and had a day off. The morning shift just goes and there is no real time for activities and people don't really want them; we can't force them. When [staff name] is here, they do about one hour of activities a day; on average." The registered manager and provider added they felt care staff had sufficient time to offer activities to people when the designated activities staff member was not there and they believed people were satisfied with what was offered to them.

Information about how to make a complaint was displayed in the entrance area of the home. Staff told us they would support people to make complaints. Speaking with us about what they would do if someone told them they had a complaint, one member of staff said, "I would listen, ask if I could help, then I would record it and raise it with management and ask them to take the appropriate action."

The registered manager showed us their complaints log, which showed there had been no complaints received since our last focused inspection during November 2016. We saw one compliment had been recorded from a relative. The registered manager told us if a number of complaints were received they would look at them to determine what improvements might be needed.

The registered manager told us they made themselves available to people's relatives if they wished to discuss anything and had an 'open door' policy. Speaking about how they gained people's feedback, they

told us they offered 'resident and relative meetings' but no one attended these. In an effort to encourage people's relatives feedback and involvement, the registered manager said that in addition to putting up a poster about planned meeting dates, they also emailed and texted relatives where possible. The registered manager added, "I think relatives just come and see me individually if they need to."

Requires Improvement

# Is the service well-led?

## Our findings

At our focused inspection in November 2016, we identified actions planned to bring about the improvements we identified had not been effectively implemented or sustained in the governance of the home. The provider's improvement plan for the clinical lead support of the registered manager had not been effective. Quality assurance systems were not always effective. We rated this key question as 'inadequate' and asked the provider to send us fortnightly action plans on how improvements would be made, which they did.

There had been ongoing delays to the provider's planned clinical support for the registered manager, who does not have a clinical nurse background. In August 2016, the provider informed us processes would be put into place for the nurse in the clinical lead role. However, at our November 2016 inspection, we found these had not been implemented and the provider informed us about an immediate change in the nurse undertaking the clinical lead role. We asked the provider to send us an action plan telling us how improvements would be made and sustained to ensure the effectiveness of the clinical lead nurse role, which they did.

At this inspection, the registered manager informed us a new clinical lead nurse had been appointed in April 2017 as the previous clinical lead nurse had decided to 'step down' from their role and resume a nursing role they had previously held in the home. The registered manager informed us some planned improvements had not been completed, such as nurses' medication competency assessments.

Staff told us they did not feel consistently supported by the registered manager. One staff member said, "I don't feel supported by the manager," and one nurse said, "If I ask the manager something, they just tell me they are not a nurse, it's not supportive here."

The registered manager told us that following our visit in November 2016, they had started to record their 'manager's daily checks.' We saw some issues were identified, for example, one person's drink had been left out of their reach and this was addressed with staff. However, other issues were noted but there was no record of any action taken. For example, a check on the accuracy of the handover to ensure all information had been documented, recorded there was 'very limited documentation'. We also found handover information was very limited, for example, nursing handover comments for people consisted of 'ok,' 'up in lounge' and 'sat in chair' which was the entire detail recorded on the handover sheet for the person's care and support throughout the shift. One nurse commented to us they had received a "poor handover" from an agency nurse.

The provider had systems and processes in place to assess, monitor and mitigate risks to people's health, safety and wellbeing. However, these had not always been effective because actions identified as needed to protect people, had not been put into place. For example, the registered manager showed us their March 2017 'residents at risk monthly profile' and saw one person had recorded 'no concerns.' However, this person's plan of care stated 'staff are to make sure they are monitoring the lounge and [person's] whereabouts.' Staff told us they had informed the registered manager they were unable to do this, at all

times, and meet the needs of this person's plan of care. The information on the registered manager's profile was not accurate and they, and the provider, had not taken steps to effectively mitigate risks to others.

The provider told us they felt they had taken all appropriate action in reporting incidents, as required, to the local authority and CQC. We acknowledged incidents had been reported but this had not effectively managed the risks posed to people. We found no referral had been made to the local authority for a review of this person's care or request to review funding arrangements so that additional staffing resources could be looked at. Following our inspection, the provider sent us a plan of immediate actions they intended to take, to ensure people who lived at the home were protected.

An audit of the home undertaken by the registered manager in March 2017 had not identified or taken action about a shower head that was not in working order or flooring that needed to be replaced because it posed a trip hazard in an en-suite; this and another area of flooring in the home was cracked and broken. Staff told us these issues had been reported by them "months ago" but action had not been taken.

The provider's system for the safe management of medicines was audited on a monthly basis. We looked at the two most recent audits and saw some issues requiring improvement had been identified. For example, the April 2017 medicine audit had looked at all 13 people's medicine records. Of these, there were ten recorded errors, such as there being extra tablets potentially indicating they were signed for as given but had not been administered. The action recorded was for the clinical lead nurse to arrange a meeting and undertake assessment checks to assess nurse's competency. However, these checks had not yet taken place which meant any further training needs were not addressed in a timely way.

The April and May 2017 medicine audits were not sufficiently detailed and did not identify the issues that we found. For example, there being no recording tool in place for the use of skin patches to ensure the manufacturer's instructions on application were followed and did not include protocols for where people were prescribed 'when required' medicines.

Checks to ensure staff knew how and when to complete records as required were not always effective. For example, one person showed us a large amount of bruising on their hand and arm which a staff member told us had been caused by a recent blood test. This person's care notes recorded the test had been undertaken, however, there was no body map to record the subsequent bruising and linking it to the test. The registered manager told us they would have expected staff to have completed a body map. A further example was given to us during our inspection when we were told about an incident and expected to find a log of it, but one had not been made.

Audits of staff employment files had not identified where there were gaps in records. For example, we found one bank nurse had no record of an induction, of any references being undertaken and no employment history in their staff file. Their DBS check was dated January 2014 and there was no record that the provider had undertaken a further check or asked this worker to complete a self-declaration. The registered manager told us, "This bank staff member has worked here for years and is well known by the provider." However, the registered manager had been unaware of the gaps in this staff record.

There was a log of accidents and the registered manager told us these were used to identify the actions needed to minimise the risks of reoccurrence of falls at the home. However, we found actions were not always recorded on their analysis or on people's fall risk assessment. The registered manager told us, for example, discussions with one person had taken place about how to reduce their risks of falls but this was not recorded. The registered manager and provider agreed that the analysis of the accident log would, in future, record all actions taken.

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

Staff team meetings and one to one supervision meetings took place. However, staff did not feel consistently supported in their role. Staff told us they felt supported by fellow care workers and nurses, however, despite regular opportunities to meet with the registered manager, they did not always feel supported or that issues raised with them were acted upon. One staff member told us, "There are 1001 things I could say, but I am not sure anything would change. I love this place and the people (who live here). I am hoping it will get better. I just feel I am banging my head against a brick wall."

Systems were in place to seek feedback from people and their relatives. A feedback survey had been sent to people's relatives during May 2017, and the provider shared their initial results from this with us. This showed 46% of relatives were 'very satisfied' with the 'attentiveness and responsiveness of staff to matters of concern to you or their family member,' and 53% of relatives said they were 'very satisfied' with the owner (provider) and registered manager, and a further 86% were 'very satisfied' with care staff. The registered manager told us the provider planned to undertake a 'resident survey' during June 2017 and would then collate results into an action plan so improvements could be made where needed.

The provider told us they had experienced some challenges since our November 2016 inspection, with some of their nursing staff being absent from work and this had delayed improvements being implemented. The provider said they hoped with the appointment of a new clinical lead nurse, improvements would be made.

The new clinical lead nurse told us, "I have met with the provider's business consultant (who has a clinical nurse background) and had an induction with them, agreeing objectives. I have planned dates for all the nurses' competency assessments and will be supporting them as well as the registered manager in clinical nursing areas relating to people's care and support."

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not always assessed the risks to the health and safety of people receiving care and treatment and had not done all that was reasonably practicable to mitigate any such risks. The management of medicines was not consistently safe. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider's systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity were not effective. Risks relating to the health and safety and welfare of people and others who may be at risk, were not mitigated. |