Saffron Healthcare Limited

Stanley Wilson Lodge

Inspection report

Four Acres
Saffron Walden
Essex
CB11 3JD

Tel: 01799529189

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Ratings

Overall rating for this service	Requires Improvement

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 the 20 July 2016 and was unannounced. The service was last inspected on the 8 December 2014 under section 60 of the Health ad Social Care Act 2008 and was rated as requires improvement overall with a number of breaches of regulation. These related to Care and welfare and insufficient staffing levels in the service. Since this inspection we have received regular action plans from the manager telling us what continued actions they have taken to comply with regulations.

There is 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 2008 and associated Regulations about how the service is run.'

Our inspection concluded that people's experiences in the service were mostly positive with people reporting good experiences on the ground and first floor but we did have some concerns about the care and clinical oversight of the care provided to people who required nursing care and resided on the second floor. These concerns were discussed the manager following our inspection and they took some immediate actions to rectify what we had found. In addition we met with the provider and they gave us a very detailed action plan which gave us confidence in the provider that they would address and had already addressed a number of shortfalls. The service in the main provided good care to people and staff were friendly, helpful and shown to provide care that was responsive to people's needs.

Insufficient staffing to keep people safe was identified as a breach at the last inspection. During this inspection we felt there were enough staff most of the time. However the deployment of staff was not always used effectively to ensure people's wellbeing and safety and there were times when people felt there were not enough staff. This was also highlighted by staff working at the service. The manager had systems in place to monitor the staffing levels in line with people's needs. The standards of care was good but people's safety could be compromised if current staffing levels were not maintained or increased according to changes in people's needs.

Risks to people's safety could be increased due to poor practices around infection control and poor monitoring and maintenance of equipment. We also identified issues with the management and storage of medicines, and creams. The care planning process required general improvements in terms of record keeping and monitoring of people's health.

People were supported by staff who had all the required training and support they needed to work effectively. However we did identify some concerns around staff practices in relation to medication management and infection control practices.

People were supported to eat and drink enough for their needs and there was close monitoring of this. However we identified a number of risks around people specific dietary needs and risks from aspiration.

Although overall care delivery was kind and caring, staff did not always treat people with dignity and respect. People's needs were assessed but we could not always see from the records that care had been delivered. Staff were familiar with people's needs. Not all the people in the service had an opportunity to interact with others in a meaningful way and live full lives including participating in activities that interested them. The complaints procedure was not always effective in addressing people's concerns.

The service had quality assurance systems in place and is constantly trying to improve the service it provides. However we identified concerns which had not already been identified or addressed by the provider. Areas of the service lacked leadership and engagement from senior staff to ensure staff practices were of a good standard and improvements were made as required. People did not feel their views were taken into account at all times and staff morale was low.

Staff had a good understanding of legislation relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberties Safeguards (DoLS). The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

People's independence was promoted as far as possible. People were consulted about and encouraged to stay mobile which could mean the risk of falls increased. However the service monitored risks and took appropriate action where identified.

We found breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 in multiple regulations. You can see what action we told the provider to take at the back of the full version of this 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 did not always safety meet people's needs.

People received their medicines safety by staff trained to give medicines. However we identified concerns with the storage and the management of people's creams.

Staff were employed in sufficient number to meet people's needs but we were not confident that staffing levels were always adequate for people's needs resulting in an increased risk to people.

Risks to people's safety was not always well managed and gaps in records keeping meant we could not always see how risks were addressed to ensure people's on-going wellbeing.

We identified some concerns around infection control practices.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were adequately supported to meet people's needs but we were concerned about some staff practices and questioned the effectiveness of staff training in some subjects.

People were supported to eat and drink in sufficient quantities for their needs and this was adequately monitored. However where people had specific dietary needs to maintain their wellbeing these were not always managed effectively.

Records did not support the fact that people got the health care they needed or that staff carefully monitored changes in people's needs so that corrective action could be taken.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with dignity and respect. Although overall care delivery was kind and caring

People's independence was facilitated.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed but we could not always see from the records that care had been delivered. Staff were familiar with people's needs.

Not all the people in the service had an opportunity to interact with others in a meaningful way and live full lives including participating in activities that interested them.

The complaints procedure was not always effective in addressing people's concerns.

Is the service well-led?

Requires Improvement

The service was not always well led

The service had quality assurance systems in place and is constantly trying to improve the service it provides. However we identified concerns which had not already been identified or addressed by the provider.

Areas of the service lacked leadership and engagement from senior staff to ensure staff practices were of a good standard and improvements were made as required

People did not feel their views were taken into account at all times and staff morale was low.

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Detailed findings

Background to this inspection

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

The inspection took place on the 20 July 2016 and was unannounced. The membership of the inspection team included an inspector, a specialist advisor who was an experienced general nurse and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone. Our expert had experience of older people and dementia care.

Before the inspection we looked at information we already held about the service including previous inspection reports, notifications which are important events the service is expected to tell us about. We also received a provider information return which gives us information about the service and how it is managed to ensure compliance against regulations. During the inspection we spoke with thirteen people using the service, five relatives, and twelve staff including the manager, care manager, domestic staff, and care staff, catering staff, activity staff and three nurses. We spoke with three health care professionals. We case tracked four people looking at their care plans and other records. We also looked at the records of another eight people in relation to specific areas of their care and medication administration.

We carried out observations of care on each of the floor, and looked at a number of records some of which were requested after the inspection.

Requires Improvement

Is the service safe?

Our findings

The management of medicines were poor which potentially put people at risk of not receiving their medicines as intended. We looked at the management of medicines but only on the nursing unit. We found some poor practice which could potentially put people at increased risk of poor care. We asked the service for a copy of their most recent medication audits. These were provided and dated June 2016 and showed that the service had been rated compliant with no actions identified.

We looked at the medical store room; on the second floor this is where the medication trolley, some medication and dressings and clinical equipment were stored. The mobile air conditioning unit was not working correctly and a towel was on the floor as it is leaking water. The temperature was showing 30 degrees. When we asked the nurse they told us the day before the temperature, had reached 40 degrees. Medication should be stored below 25 degrees. For medication to remain effective it is recommended for most type of medications that these are stored below 25 degrees at all times. High temperatures could affect the efficacy of these medications and people's care and treatment. The staff reported that it had been reported to the maintenance person and there had been problems with the temperature control since the weekend because it had been unseasonably warm.

The fridge where medicines were stored was showing a temperature of 11 degrees, it should be 8 or under and the nurse said that the temperature of the fridge had been elevated since the 19 July 2016 and medications, such as Insulin had been moved to the medicines fridge on the middle floor. They told us they had also reported the fridge as faulty. Although action had been taken medicines not stored at the correct low temperature could become less effective.

The last audit was dated 12 June 2016, and the score achieved was 96%. Any score below 90 % would require immediate actions by the provider. We looked at medicines against the audit and saw all boxes of medication we checked were dated when opened and accounted for. However the audit did not include the correct use of topical applications and we identified concerns with these. These included a lack of guidance for staff who were administering the creams as to the purpose and frequency of administration. The nurse told us there was guidance for care staff in the person's care plan. We looked at care plans and saw no body maps to show where the cream should be applied. Daily notes viewed said applied cream but for some people prescribed more than one cream; care staff were not recording which cream was being applied. Creams seen had no opening dates; this was of concern as the risk of infection increased for creams opened for more than 28 days unless they had a pump action. We found other creams in people's rooms which were not dated or named for that individual. We checked with the nurse and established that there were no systems in place to ensure people were only given creams that were prescribed for them and a date of opening recorded on all creams. On bringing this to the manager's attention they informed us creams which had not been dated were to be disposed of and replaced and all creams in future would be dated.

We checked a number of medication administration records, (MAR) and identified a number of gaps in recording so we could not be assured if the medicines had been given or deliberately omitted as there was no explanation on the back of the MAR sheet. Where tablets were not in blister packs the service were

recording the total number of tablets in the boxes and we identified some gaps in recording.

We looked at pain patches. A body map was used to record the site the patch had been applied to but there were gaps in recording. Not recording skin sites used for transdermal patches, especially for a daily change means that a person's skin can easily become inflamed if sites are not rotated to give the skin time to recover.

The home had a daily medication check but this did not identify any gaps in recording that we had identified so we were unable to see if any actions had been taken. Omissions of signatures had not been identified as part of the daily medication check. We spoke with the nurse about this who told us sometimes the nurses were forgetting to count the tablets against the agreed recorded stock.

Syringe drivers were in the service to help manage people's pain. However the equipment had not been serviced according to the service schedule should have been on the 26 February 2016. We raised this and told it had been booked for next month.

We briefly observed medication administration and this was done safely with staff taking their time to ensure people took their medicines before they signed for it. They also gained people's consent. Medicines were kept securely. However staff administering medicines were on occasion distracted by people using the service which could increase the risk of error.

Staff administering medication were required to complete medication competencies. Observations were undertaken every six months. Staff also completed medication e-learning and training via the medication supplier. Although these observations and staff training was in place it did not mitigate the errors and concerns we found, therefore the provider needed to consider the effectiveness of their systems for training staff in medication management.

We observed poor infection control procedures on the nursing floor. Risk of infection was increased by poor practices around creams and poor hygiene practices demonstrated by care staff. We observed care staff placing soiled linen and soiled wipes on the carpeted floor, prior to it being taken to the sluice room. There was no trolley, bag or bin to place the linen or wipes in Staff did not wash their hands before and after given personal care before moving on to assist someone else. Care staff did not wear aprons over their clothing whilst giving personal care and this involved the removal of soiled incontinence pads and soiled linen. This is poor practice as it could lead to cross infection. Staff did have disposable gloves on. We also observed staff on the nursing floor using the same manual handling sling for two people one after another. When we asked the manager they confirmed people did have individual slings and told us they would address this with the individual staff members. We also noted the lunch time trolley was still on the nursing unit at 4.25pm, dirty plates and unused, uncovered food was visible.

We identified a number of risks to people. A store room on the top floor contained all the fuse panels for the unit, it had no window or ventilation, and it did have a fire sensor. The room has mattresses and bed frames, commodes and furniture stacked almost to the ceiling. We were unable to get into the room, as the doors would barely open and spare wheelchairs were not belonging to anyone. This was discussed with the manager at the time of the inspection and was dealt with straight away but had not already been identified by the service.

These failings demonstrated a Breach of Regulation12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Despite these specific concerns we found all areas of the service visibly clean without any unnecessary clutter and no odours other than in one specific area.

At the last inspection in December 2014 we made a compliance action around inadequate staffing levels. At this inspection not all the feedback we received was positive about staffing levels but we considered the service to be compliant. The manager told us staffing levels had been increased at night and in the morning and in additional they had a breakfast assistant to support care staff.

One person told us, "It is very good here but not so good when you don't have enough carers and it has happened several times recently. I don't think they have enough at night only 2 and they are occasionally short at lunchtime." A relative visiting her family member on the dementia care unit expressed concern about the staffing levels and said that communal areas were sometimes left unsupervised and they felt this was unsafe.

Another relative on the dementia care floor said, "They say that they are short staffed but they do not seem overly rushed."

Some staff said the service can be short staffed. One member of staff gave an example of a staff member going off sick and not replaced. A staff member on the residential floor said one person at the moment needed constant supervision which meant staff were really pushed when they did not have all the staff required. Staff told us there was a problem at the weekend with staff going off sick at short notice. We asked the manager about this and they told us they were on call and would call agency staff as required.

On the day of our inspection we found that the service had the number of staff it said it needed and staff were observed working cohesively to meet people's needs. We based ourselves on the three different units: the ground floor is for people who require residential care, the first floor for people who are living with dementia and the second floor for people who required nursing care. There was a registered manager overall, and a care manager and a nurse working on the nursing floor on each shift. The nursing unit had 18 people resident at the time of our inspection.

During our observations we saw people's needs were met in a timely way and staff were usually visible in the communal areas but found after lunch on the dementia unit that supervision of people was reduced and people were mobilising without support and a number of people were unsteady on their feet. Staff were in the vicinity but not fully aware of what the situation was. This was brought to the managers' attention. When we spoke with relatives and people using the service they told us calls bell were answered quickly. We did not hear any call bells on two of the floors during our inspection apart from an emergency bell which was responded to quickly.

Since the last inspection the manager has sent us regular updated action plans stating how they understand they are compliant with the regulations. In relation to staffing the manager told us there were regular audits and observations of care which would quickly identify if there were not enough staff. They told us they carry out observations of practice and ensure each person had a regularly updated dependency tool which feeds in to an overarching dependency tool. This was updated monthly. This helped the manager to match the number of staffing hours required to meet people's assessed need. In addition the manager said regular assessments on people's needs helped to determine if the service was able to continue to meet a person's needs and said in a number of instances a person was identified as needing more support than the service could offer. People have moved between or to another service when appropriate to do so. The manager said they had increased their staffing at night as a result of feedback given by inspectors after the last inspection. In addition they told us they employed breakfast assistants to support the care staff and help promote

people's food and fluid intake.

The manager said there were no vacancies and a number of staff were leaving but their posts were already recruited to. This ensured the service was not left short. They told us they over recruited to posts.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in December 2014 we found staff were not supporting people sufficiently to eat and drink enough for their needs and records were not up to date. We made a compliance action and rated effective as requires improvement. At this inspection we had continued concerns about the effectiveness of the care being provided.

People's care plans were informative and up to date in most cases. However there were a number of gaps. For example: a person on the dementia unit's care plan confirmed that they required specific support in regards to their bowel movements. The care plan specifically instructed staff around timescales for action if the person needed support with their bowels and what medication was required. The person's daily care records showed neither records of bowel motions nor a record of medication being administered to alleviate constipation for a period of twenty- eight days. We checked this with the manager and they confirmed there were no entries. We therefore could not see how staff were monitoring the person's healthcare need. The same person was also prone to urinary tract infections but could not see how staff were monitoring this. Their daily notes indicated at times they were 'agitated,' this might be symptomatic of an infection or behaviour resulting from their dementia. However it was difficult to establish this from the daily records.

We spoke with the deputy manager about how they monitored people's specific health needs, for example bowel care. They explained to us that all records were now electronic and if you put in a key word of "bowel," entries would come up. However we could not see how often nurses were checking this information and they were relying on care staff to report a concern. This was not an effective method of monitoring bowel movements and problems could easily be missed as regular monitoring by the nurses was not always occurring. The electronic information seen was sometimes uninformative and only partially completed. We were unable to see how staff were closely monitoring people's needs and a lack of regular recording made it difficult for us to assess if people's needs were being met.

We had concerns about the management of people's diabetes. The regular chef told us that currently there was no one who was diabetic using the service. This was not the case. On the menu recording sheets we looked at there was no information for care staff about who was or was not diabetic. We reviewed the care plan of a person with diabetes and there was guidance around their dietary needs. This had recently been reviewed and a recommendation had been made to ask for additional advice from a dietician. There was no evidence that this had happened. They were required to be weighed weekly and we saw in practice this was not happening although their weight was fairly static. The last weight record was 26 June 2016.

One person with a nursing need had unstable diabetes and was insulin dependent. Their needs had been reviewed by the diabetic nurse who was happy how the staff were managing their diabetes by giving additional doses of insulin to stabilise the effects of sugar in their diet. This enabled the person to choose what they wished to eat. However during our observations the nurse recorded a high blood sugar level before lunch. The nurse said this would be managed by giving the person the main meal but no pudding as it was gateaux and cream. When asked if there was an alternative desert to be offered they said no. In

practice this person was given a chocolate desert by care staff which had very high sugar content. We also noted people were given snacks mid-morning. This included jellies. They were not low sugar and were given to people with diabetes. Foods with lower sugar content could help regulate their blood sugar levels which were unstable. The person required additional injections of Insulin in order to try and maintain a more normal blood sugar level. Poor management of diabetes could result in the person possibly feeling: thirsty, drowsy, have headaches and feel generally unwell. The persons care plan did not state that they had chosen to eat high sugar foods instead of healthier options. Healthier options were not made available or offered during our inspection. This placed this person's overall health and wellbeing at risk.

One person on the ground floor told us, "They weigh me regularly and I have a blood test once in a blue moon. I am diabetic – they make me lovely cakes and they give me cakes and cakes – I take tablets. They don't test my urine, I have put on weight, I was 8.5 stone and now I am 11.5 stone – it is all the cakes."

These failings demonstrated a Breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Most people did tell us their health care needs were met. One person said, "We are seen by the GP, and Chiropodist here but I go to the opticians." Another confirmed they had recently been seen by chiropodist and dentist.

Gaps in records could compromise people's health. Daily bed rail checks were in place for some people and there was a place on the form to indicate if these were fitted correctly. We observed care staff ticking the form to say the bumpers were fitted correctly. We then went to check the right side of the person's bed and saw they had a bumper just attached at the top; the lower section had not been fastened, so it gave no protection and no barrier to a person putting their arms or legs through the bed rails. There was another form which recorded daily pressure relieving equipment and moving and handling sling checks which correctly recorded a person's weight and mattress setting. However there was no detail of the size or type of sling care staff should use. This information was in the care plan but not adhered to be staff. When care staff were asked about using slings they said they used a communal sling.

We reviewed a person's care plan who had dressings. This was recorded in their care plan with a body map showing where the wounds were but no photographs. The wound entries were not regular with the last entry being on the 8 July 2016. The person had two wounds and there were only records for one. We checked their daily notes and it did not tell us how the wound occurred or how they should be treated. This was poor practice; the wounds have not been assessed properly for size, depth or cause. There are no photographs to monitor progress. The type of dressing used has not been recorded and there was no evidence that the dressings have been changed on the leg area since 8 July 2016. There was no record made of the arm wound, this meant the wound was not being effectively managed to ensure it healed appropriately and causes minimal pain or discomfort to the person.

In a cupboard there was a suction machine, the suction catheters were in the store cupboard. This meant that there might be a delay if this is needed in an emergency. This was poor practice to not check equipment thoroughly and have it ready to use immediately. If someone choked and needed assistance, there would be no time to look in different areas for equipment. In addition, during our observations we noted several people not being made comfortable and supported sufficiently prior to being aided by staff with their meal which could increase the risk of aspiration.

Weekly checks of clinical equipment: were carried out but records showed gaps the last entry being the 10 July 2016 and they were not being done weekly. The audits had not identified the issues we had.

We recommended the service refer to current guidance around suction catheters, and ensure all equipment required is in stock and tested according to the manufacturers instruction.
We also identified a glucometer with out of date testing strips, which the nurse confirmed they would dispose of these.
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We identified concerns about the contemporaneous recording of fluids. We saw regular fluid entries on people's records but we had observed staff giving people drinks which were not recorded or sometimes handed over to other staff to record. This made the records unreliable. Staff were not able to tell us if people had individually agreed fluid protocols and at what point staff should flag up a concern. However the deputy manager said they did review each person's fluid totals each week and would raise concerns with the GP. They produced files of evidence for this showing how they collated information about each person and was able to show anyone at risk or malnutrition/hydration.

Temperatures in the service on the day of inspection were excessive. Windows were open and there were a number of fans around. People were being encouraged to drink but some were reluctant to. One person on the day of our inspection and one person since had been taken to hospital suffering from dehydration, and/or infection. The paramedics expressed concern about the lack of action taken to reduce the person's temperature prior to them calling the doctor.

Records for how often people's position was changed to help promote their skin integrity contained gaps and did not help us determine if this was done frequently enough. For example one person's record showed a 17 hour interval. This had not been identified by the service. Some records said the person should be turned at regular intervals without determining what regular meant. Staff asked said every three to four hours but this was not demonstrated by their records. Records also did not always tell us what position people had been in with records stating repositioned.

These failings demonstrated a Breach of Regulation12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the last inspection in December 2014 we identified a breach in regulation in relation to care and welfare and in particular the monitoring of people's food and fluid intake to ensure it was adequate for people's needs. For this reason we involved a nurse specialist as part of this inspection. We did some case tracking on both the nursing and the dementia care units. We found that staff were monitoring what people were eating and drinking but there were some aspects of people's health care which were not monitored so well.

We asked people if their dietary needs were met and about the quality and availability of the food. One person told us. "Food is very good and they will always go and get something else if you don't like what is on the menu."

However other people were less complimentary about the food and we saw this had been discussed at residents meetings and an alternative lunch menu had been introduced. Comments included: "Supper time, I only get what is left, soup you never know what sort it is going to be. Sandwiches I ask for cheese or ham and get them occasionally and they give me tuna which I don't like and they gave me egg but it was a fried egg in the middle, did not like that and never asked for that one again – bread not always buttered on both pieces" However when we went in the kitchen we saw bread being buttered and both sides were buttered by the cook.

A relative said, "Food is tasteless. Breakfasts are fine. If it says stew and dumpling it comes without the dumplings"

Another person told us, "Sandwiches and yogurts ran out last week so I only had a cup of tea"
"We brought food up at the meeting and discussed it. It is brought up at every meeting but there is never any change. "They start the tea service down by reception and by the time they get to hear things have already run out."

Another person said," it is terrible, they over cook everything and the food in monotonous. Breakfast the porridge is ok, the veg is overcooked and every day it is the same kind of menu funny meat with gravy to cover it – the chips are limp." Out of nine people spoken with about the food seven made negative comments about the food.

Staff told us that sandwiches were made up in the morning so they are not fresh enough, one staff member said, " Giving jam sandwiches for all is not appropriate, it is different if someone asks for it." Staff said they sometimes bring food in for people that they have requested. Staff said people complained a lot about the food being provided. Staff also confirmed that sometimes they ran out of food. On the dementia unit we noted that staff ran out of blackcurrant squash and told people they could not have it which restricted people's choice.

During meal times not everyone was in an appropriate position to eat. A number of people were not propped up in bed and a couple of people were still in a reclined position in their chairs making it difficult for them to eat. We noted people did not always get the assistance they needed; one person's food went cold whilst waiting for staff assistance and several people's food was not cut up to aid their independence as required. On the nursing unit one person was given their food and ate unassisted but started to cough. The nurse came in and told the care staff they had given the person the wrong food and replaced it with a pureed option. We looked at the menu sheet and it clearly stated who should have a pureed diet. The services response to people's concern about the food had been minuted in residents meetings and included the introduction of a new menu which did not appear to have been effective at addressing people's concerns.

This failing demonstrated a breach of regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The chef told us there was a four week menu and they did cooked breakfast for all on two days but usually get requests from 12 on most days for a cooked breakfast which they do. They said there were two options for lunch and two options for tea with soup/sandwiches and a hot tea dish.

We observed the lunchtime period on each of the respective floors. The care staff wore tabards over their clothing. Hot trolley came to the respective units and staff probed the food and recorded the temperatures. Food was served efficiently, on the dementia care unit staff plated up the two menu options and gave people a visual choice. On other floors people were asked what they wanted to eat the day before. We observed on the residential floor that people were encouraged and offered suitable choices. Staff tried to accommodate individual tastes and were people refused the main options they were asked if they wanted something else. Through our observations we saw staff promoting people's food and fluid intake. It was a hot day and drinks were made available.

Staff received the training and support they needed. However, improvements were needed to ensure that staff training was imbedded in their everyday practice specifically in areas such as infection control, medication management and supporting people's nutritional needs. One person told us, "Very good here, well trained staff and they go beyond their training and are good human beings."

We spoke with staff about their training. One staff member told us people's needs had changed and there were a lot of people on the ground floor with dementia. They said they had attended about four sessions on dementia care and said staff were well supported. Another member of staff new to care told us about the training they had done both practical and e-learning. They explained the manual handling training and said there were pictures of manual handling moves and equipment and said they had practiced using the hoists. They told us about caring for people with dementia and how they had life stories for people which helped them understand people's behaviours.

Most staff spoken with were long standing staff as there was a good retention of staff. The service used its own staff and rarely relied on agency staff. The service ensured all staff received an induction and the manager provided us with a training matrix and a supervision matrix. This showed that most staff had received regular supervision and this might also include direct observations of their practice against agreed standards of competence. Staff also had annual appraisals of their performance.

On the walls of the individual units were lists of staff holding first aid qualifications and staff identified as fire marshals. The manager said there were a number of staff who had a specific interest in different areas of health care and they were staff champions and a point of reference for other staff. This included infection control, end of life care and dementia care.
We recommend that the role and function of staff champions be reviewed as these had proven ineffective in some areas such as infection control.

Staff had a good understanding of the Mental Capacity Act and said they involved others, both families and health care professionals in decisions if the person could not make them themselves. We saw a record relating to choice and any factors the service needed to take into account about the persons preferences. Staff promoted choice and did so in an appropriate way for their needs.

The service had policies in place to help support staff around their understanding of the Mental Capacity Act 2005 and The Deprivation of Liberties Safeguards. Staff demonstrated sufficient understanding when we spoke with them and had received training. We saw evidence that referrals had been made to the Local Authority applying for Deprivation of Liberty for people who would not be safe to leave the service.

For one person we saw a record which had room to record if the person had a power of attorney for care and welfare, and or finance but this had not been completed. Gaps in record keeping were raised with the manager.

During our inspection we spoke with a number of health care professionals and received written feedback from another. One said, "I have found the staff here friendly, patients are clean, it is not too difficult to speak to staff when I ring, patients are well looked after. I have no immediate concerns." Another said that staff were knowledgeable about people's needs and always had information to hand. They felt the home made appropriate, timely referrals and they were not concerned about the care provided. One professional confirmed there was a matron who visited the service twice a week and there were daily visits by District nurses. The health care records did show good referrals to other services as required and showed things were being identified and actioned.

Requires Improvement

Is the service caring?

Our findings

People's dignity and choices were not always respected. One relative raised a concern about her family member having a male care worker which they said their family member did not like. They did say the staff member was respectful. However we noted in people's records that they were asked about their preferences in relation to gender and were not clear this was always being respected.

Most of the interactions we observed were respectful. We noted nurses knocking before entering people's rooms but noted a number of care staff walking into people's rooms without knocking or waiting for permission. We also noted a health care professional treating someone in the communal area which we brought up with the manager for them to address.

The quality of staff interaction varied, on the dementia unit we noted staff were kind and respectful but we noted one staff member assisting a person with their meal whilst standing over them and not maintaining eye contact. Another staff member assisted someone with personal care and did not lock the door which resulted in another person entering the toilet. On the nursing floor we noted care staff not giving eye contact or initiating in conversation when supporting people with personal care. People sat in the lounge had the television on which inhibited conversation. On the dementia care unit, we observed different areas of the home with different areas for people to sit in. One person was in the lounge with the television on but they were asleep, another two ladies were chatting in the hall and other people were sitting and socialising in the dining room. Appropriate music was playing and people were responsive to it.

However, people spoke highly of the care staff and the care provided. One person told us, "They are lovely carers, we get on alright, and they are all friendly. " Another said, "Staff are nice, lovely and really respectful.", "I know all the staff well. They are really good. Carers are very good helping me up in the mornings, they are never unkind but night staff are tired when they get me up at 7 am."

Most of our further observations were positive and showed caring interactions from staff. One person praised the activities and said staff always included them and came and fetched them. They said, "They do my nails each week." We observed them laughing together. We noted care staff asking how people were and ensuring they were comfortable and their drinking glass was topped up. We saw care staff maintaining good eye contact with people and stopping to have a chat.

We observed staff and their interactions with people using the service on each of the separate units. As you walk into the home there is a reception area and relatives and visitors can help themselves to drinks and meet in private. The home is light and airy and there is a lot of information for people about the service and contact details of different organisations should they have any concerns. A relative told us, "It is absolutely smashing here the staff care is professional caring and friendly. They keep me notified of anything and everything and they could not be more helpful. My family member has been to the hospital three times and they have been magnificent."

The home is designed in a way to meet people's needs with ample opportunity for people to able to

socialise with each other or have private time. We observed staff who were engaging with people and were familiar with their needs. One person said, "Staff are very good and they help me wash and dress and they take a bit more time the care here is wonderful."

Requires Improvement

Is the service responsive?

Our findings

We spoke with people about the care and support they received and most were complimentary. One relative told us, "They take part in the singing and the cards and go every time."

One person told us, "I read my Times every day and sit in reception, go to the dining room for my meals, I wake up and eat about 8 o'clock and go to bed around 9 at night it's my choice." Another said, "It is gardening today but it is so hot, I go to play your cards right, started to go to card games here and they are fun, go to bingo, the singing things, holy communion every 2-3 weeks, and the trolley shop comes round once a week."

We asked staff about activities. One person told us, "We have got good links with the schools at least four come in and the Salvation Army come in. There was a Jubilee party and children from one of the schools came and sang. Local paper comes and covers our events, Church Holy Communion is once a month, craft shop in town makes muffs for the dementia floor and they come round, volunteers come and help, one person comes in and reads to a blind person." Another member of staff told us there were limited one to one activities and some people were too frail to join in.

They told us there was a Newsletter which people could have a copy of and people were asked daily about whether they wished to join in activities.

We observed on the ground floor that some people were doing their own activity including reading the newspaper, word searches and colouring. There were activities planned people told us they enjoyed them.

However we did not see much activity for people on the dementia and nursing floor. On the dementia unit we did see some really nice interactions/friendship groups. Staff interaction was regular but fleeting. People were asked if they wanted to join in but did not express any interest. A relative told us people required one to one support to join in anything. The manager said this was provided but this was not observed during our visit. The manager told us there was a therapist who came in monthly and offered therapies such as foot spa and had a sensory trolley which especially benefited people with dementia and high nursing needs. There was 50 hours of activity but this was across the whole service.

On the nursing unit we did not observe any organised activities being provided. The television was on all day in the lounge and we did not observe care staff sitting with people and trying to engage with them outside of meal times or when offering drinks. We did not see any books, magazines or objects to give interest to people using the service which was in stark contrast with the dementia unit where there were memory boxes and lots of tactile objects and relevant wall art. On this unit we also observed people relaxing listening to music, taped bird song or able to just sit quietly.

We case tracked four people and found the care plans were informative and included an assessment of people's needs and risks associated with their care. The service had a resident of the day which meant their needs were reviewed on that day and took into account all aspects of their experience within the service in

relation to their care. We however found records were not always completed with the regularity that they should be and have given examples elsewhere in this report such as in relation to skin integrity and how often a person should be turned, weight records, wound care and monitoring of incontinence. The daily notes did not always give us sufficient information about how the person's needs were being met or how people had been throughout the day. Descriptions of people's behaviours were not always very detailed. One person was described as agitated. Some agitation was reported around help with personal care but it was not clear why the person found this difficult and if there were things which might help the person feel less anxious. The care manager said each week they reviewed every person and reported on any changes to the person health status such as weight loss, any falls or change to their general health. In addition, the manager told us they had introduced a daily 11.00am meeting where all the Heads of Department got together and discussed any immediate concerns which required attention. The units had handover books on each floor which were used to disseminate information from one shift to another.

The service collated complaints and compliments and we saw actions the manager had taken to address people's concerns. However a number of people told us they had raised concerns and did not feel these had been adequately responded to or that things had really improved as a result of their feedback. Examples we have given were around the quality of the food and arrangements for laundry. The manager showed us a number of recent compliments where the service had been well received. Throughout the service there was a lot of information about how people or their relatives could raise concerns and to whom if they had any about the care and, or safety of people living at the service.

The manager showed us a number of recent compliments where the service had been well received. One relative had commented on how the service had cared for both their parents and said the service provided exceptional care and said it exceeded care standards. Another relative spoke about the kindness and patience shown to their family member and said that staff had attended their father's funeral. They were complimentary of the whole team and felt staff help and kindness often went unrecognised. We also saw press coverage which showed a person using the service actively fundraising for the service and complimentary feedback from their family members.

Requires Improvement

Is the service well-led?

Our findings

The provider's quality assurance systems, although in place, was not always effective in identifying areas of the service and care delivery that required action or improvement. We identified concerns regarding staff practice, medication management, infection control procedures, meal quality and record keeping within the service. None of these areas had been highlighted by their own processes placing people at risk.

Although we had received some positive comments from staff about the service and its leadership, overall staff were stressed and felt overworked. One staff member told us, "Morale is very low." Others said staff shortages put them under pressure. Staff were often working long hours. We spoke with staff who worked long days and some staff worked both days and nights. They did not feel this impacted on the care they gave. However a number of people commented on how tired the staff were.

Many people at the service were very frail with a nursing need or living with dementia. We asked the manager for evidence of how they effectively measured the standards of care provided to people who might not be able to tell staff about their experiences. The service completes a quality service review which is matched against CQC standards and is repeated throughout the year. This uses evidence through case tracking and observation and ensured appropriate actions were taken in meeting the standards. This had not always been effective as we identified concerns in several areas of people's care delivery.

A number of people told us their suggestions were not always acted upon and a relative told us at the relatives meeting they mostly discussed fund raising and specific activities which they said were not relevant to their family member as they did not join in anything. In addition we saw the most recent residents meeting held in June 2016. This highlighted issues such as food, activities and fire safety after a recent incident. These showed actions had been taken as a result of feedback from people using the service. For example an alternative menu had been introduced however this had not been effective in reducing some people's concern about the food. There were also separate relatives meetings of which we saw the minutes for. These were not well attended which meant some people's views might not be represented.

Care reviews were regularly held to ensure the service was continuously meeting people's needs. However we identified some gaps in both record keeping and in how people's care needs were met and these had not been identified by the service.

We observed care on each floor and saw that care was given cohesively on the residential and dementia care unit but felt on the nursing floor there was no clear leadership or direction for care staff.

The unit was led by the Care Manager, who was working as supernumerary to the staffing levels. This should mean that they had time to review practices on the unit and ensure that Registered Nurses' follow protocols and procedures that they puts in place. This was not the case and their support had been ineffective in some areas to ensure people's safety and welfare.

Monitoring and working with the care staff was not a priority to raise standards within the unit. Meetings

were held in the service daily to discuss any concerns, risks to people using the service and this involved heads of departments and the registered nurses. These had not been effective in identifying the concerns we raised during our inspection in relation to areas such as infection control, poor meal experiences, medication management shortfalls and shortfalls in staff practice.

Daily information was put on the computer system by the manager and submitted to the regional manager monthly. This included information about staffing hours, any sickness, training undertaken, and anything affecting the well- being and, or safety of the service: like falls and weight loss. This enabled the regional manager to remotely monitor the service and any risks as well as carrying out regular monitoring visits to the service. We looked at audits and they including case tracking but there was little evidence of discussing issues with people using the service. There were observations of what was happening at the time of the visit. Call bell audits were included and showed good response times.

We had been notified of a number of falls at the service resulting in injury. We saw the service has a falls register and carried out an analysis of any falls to see if there was anything that could be done to reduce further falls, care plans and risk assessments were updated. We saw referrals were being made to health care professionals and reviews of people's medication. They said if a person had three or more falls they would automatically be referred to the falls team but they took about two weeks to pick up these referrals. We did not see that staffing had been reviewed in response to a spike in falls.

These failings demonstrated breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service were part of the PROSPER project which is an award winning project which supports services in managing avoidable admissions to hospital. The project supports the manager and staff and helps them to review their practices and monitoring around urinary tract infections, falls and hydration. One of the initiatives was to place a pink dot on a person's door to highlight those most at risk of dehydration. A number of staff were part of this project but none of the night staff were involved which we felt could be useful. The manager told us about a project relay with Care which was an initiative between Care Homes and the Prosper Project from Essex which aim was to raise a positive profile of living in care homes and raising money for charity.
People were aware of who was in charge and consulted about their care. One person said, "I think it is bloody fantastic." A staff member also commented, "It is lovely here, I only come to work for the residents and we treat them as our family."

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014. Person centred care: We identified a breach relating to this specific regulation: 9, 1 (a) The care and treatment given must be appropriate to people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment: We identified a number of breaches relating to this specific regulation including: 12 (2) E, The provider must ensure that the equipment used by the provider is safe for use and used in and safe way. 12 (2) G The provider must ensure the safe and proper management of medicines including ensuring medicines are stored at the correct temperatures and that creams are used as directed and disposed of as requ

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to demonstrate how it was meeting people's nutritional needs

according to their wishes and preferences and doing so safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. The provider must ensure that they fully assess, monitor and improve the quality, effectiveness and overall satisfaction of the service. Accurate, complete and contemporaneous records must be kept and demonstrate how the service is assessing, monitoring and mitigating risks to people using the service. The provider must act on feedback received from people and show clear evidence of how they have done this.