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Threen House Nursing Home

Inspection report

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18 January 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 12, 13, 17 and 18 January 2015. The visits on 12 and 17 January were unannounced and we told the provider we would return on 13 and 18 January to complete the inspection. At our last inspection in July 2015 we found six breaches of the Regulations. At this inspection we found the provider had made some improvements to the way they managed safeguarding concerns and complaints but they had made little progress to ensure care was delivered safely or improve the monitoring of the quality of the service.

Threen House Nursing Home is a registered care home for people who require nursing or personal care. The service can accommodate up to 26 older people. At the time of this inspection, 17 people were living in the service and three people were staying for periods of respite care. Some people using the service had general nursing needs and others were living with dementia.

The service had a registered manager who had worked in the home for more than 20 years. The registered manager told us she had submitted her notice and planned to work part-time in the service as a nurse, once the provider appointed a new registered manager. 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.

Medicines were not being managed safely, and people were not always receiving their medicines as prescribed.

The provider did not always deploy staff effectively to make sure people were cared for safely.

Records showed staff had completed some training but there was no evidence the provider had checked staff understood the training they completed and applied it to their daily work.

The provider did not have systems to support staff through the use of supervision or appraisals.

There was little evidence people were involved in planning the care and support they received.

The provider did not operate effective systems for planning the care and support people received.

The provider had not displayed the service's Inadequate quality rating from our last inspection.

Although the provider carried out some checks to monitor the quality of the service provided, these were not always effective.

The registered manager did not fully understand their responsibilities in relation to the Mental Capacity Act

and the Deprivation of Liberty Safeguards. People's liberty was not restricted unlawfully but the registered manager did not always follow the principles of the Mental Capacity Act 2005.

The provider had improved the management of safeguarding incidents since our last inspection.

The provider had improved the way they managed complaints. There was evidence the provider recorded and investigated complaints.

Care records showed people accessed health care services.

Some people and their relatives told us staff were caring. Most staff were gentle and patient and took time to speak to people and understand their wishes.

Some staff had little interaction with people using the service or the people they were working with. Other staff were much happier, talking with people and each other, smiling and welcoming.

People using the service, staff and relatives commented positively about the provider.

Some health and safety checks and audits the provider completed were up to date.

The provider sent quality surveys to people using the service and their relatives. 93% of people who responded rated all aspects of the service as 'excellent'. 7% of people rated all aspects of the service as 'good'. Nobody rated any aspect of the service as 'fair' or 'poor'.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report. We have also made two recommendations that the provider ensures all staff are aware of local safeguarding policies and procedures and refers to guidance on providing meaningful activities.

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

The service will be kept under review, and, if we have not taken immediate action to propose to cancel the providers registration of the service, will be inspected again within six months.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not being managed safely, and people were not always receiving their medicines as prescribed.

The provider did not manage possible risks to people using the service.

The provider did not always deploy staff effectively to make sure people were cared for safely.

The provider had improved the management of safeguarding incidents since our last inspection.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Records showed staff had completed some training but there was no evidence the provider had checked staff understood the training they completed and applied it to their daily work.

The provider did not have systems to support staff through the use of supervision or appraisals.

The registered manager did not fully understand their responsibilities in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards. People's liberty was not restricted unlawfully but the registered manager did not always follow the principles of the Mental Capacity Act 2005.

Care records showed people accessed health care services.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Some people and their relatives told us staff were caring. Most staff were gentle and patient and took time to speak to people and understand their wishes.

Some staff had little interaction with people using the service or the people they were working with. Other staff were much happier, talking with people and each other, smiling and welcoming.

There was little evidence people were involved in planning the care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider did not operate effective systems for planning the care and support people received.

The provider had improved the way they responded to complaints. There was evidence complaints were recorded and investigated.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not displayed the service's Inadequate quality rating from our last inspection.

Although the provider carried out some checks to monitor the quality of the service provided, these were not always effective.

People using the service, staff and relatives commented positively about the provider.

Some health and safety checks and audits the provider completed were up to date.

The provider sent quality surveys to people using the service and their relatives. 93% of people who responded rated all aspects of the service as 'excellent'. 7% of people rated all aspects of the service as 'good'. Nobody rated any aspect of the service as 'fair' or 'poor'.

Threen House 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.

This inspection took place on 12, 13, 17 and 18 January 2015. The visits on 12 and 17 January were unannounced and we told the provider we would return on 13 and 18 January to complete the inspection.

The inspection team on 12 January comprised two inspectors, a pharmacist inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of caring for a person with dementia. On 13 January, the inspection team consisted of two inspectors. On 17 and 18 January, one inspector returned to the service to complete the inspection.

Before the inspection, we reviewed the information we held about the service. This included previous inspection reports and notifications the provider sent to us about significant incidents affecting people using the service.

During our visits, we spoke with 15 people using the service and the relatives of four other people. We also spoke with 10 members of staff, including the provider, the registered manager, the quality assurance manager, nurses and health care assistants. We observed the care and support people received and reviewed records the provider kept in the service. These included eight people's care plans, daily care notes completed by staff, medicines records for 17 people using the service, staff rotas, eight staff recruitment files, incident reports and the provider's complaints record.

Following the inspection, we spoke with five relatives and received comments from the local authority's

safeguarding adults team.

Inadequate

Is the service safe?

Our findings

Medicines were stored on a locked medicines trolley. The trolley contained some medicines that were no longer in use. We also saw two boxes of dioralyte sachets in the clinical room; however they had not been prescribed for any person using the service, did not have dispensing labels, and were not listed on the domestic medicines policy for the service. The nurse on duty held the keys to the medicines trolley at all times.

Controlled drugs (CD) were stored in a locked CD cupboard which was secured to the wall of the clinical room. Controlled Drug (CD) balance checks were completed each day by two nurses. When a mistake was made in the CD register, words were crossed out and it was difficult to ascertain who had made the amendment.

The clinical room was very small, and was used to store care plans, medicines administration record (MAR) charts and numerous other records as well as the medicines fridge. One of the shelves in the clinical room had become dislodged with screws exposed. Three out of the 12 liquid medicines seen on the medicines trolley had the date of opening written on the bottle.

Most medicines were dispensed in their original packs with a dispensing label. One person, who was recently admitted, had medicines dispensed in a multi-dose blister pack. The pharmacy had not included any descriptive information on the multi-dose blister pack therefore there was no way for the nurse to identify whether the medicines that were being given to that person were correct.

Minimum and maximum temperatures for the medicines fridge were recorded each day; however the current temperature was not recorded. It was unclear whether the fridge thermometer was being reset correctly. There was no evidence that the ambient room temperature where medicines were stored was recorded.

Medicines were usually administered by the nurse to people whilst they were in the communal areas. We were told that if there was a person in their bedroom who required medicines, the nurse would dispense the medicine and give it to a health care assistant (HCA) to give to the person. The HCA would then take responsibility for administering the medicine, and tell the nurse when the person had taken the medicines. The nurse would then sign the MAR chart. This unsafe practice meant that the nurse could not be sure that the medicines had been taken correctly by the person. We did not see evidence of medicines administration training and subsequent competency assessments to ensure that the HCAs were suitably trained and competent to carry out this medicines administration task. There was no formal framework in place for the delegation of this nursing task to the HCAs.

Bottles of alcohol (white rum, whisky, and port) were stored in the communal conservatory area which all residents and staff members had access to. No risk assessment has been completed to show that staff had thought about the possible problems associated with this practice. We were told that alcohol consumption was discussed with the GP; however there was no documented evidence that this discussion had taken

place.

Records were not kept of all medicines that were awaiting disposal; however records were made in the CD register regarding CDs for disposal. Medicines awaiting disposal were not stored securely in a tamper-proof container within a cupboard. We observed a yellow clinical waste bin filled with unwanted medicines being stored in the nurse's office in the basement. We were told that the contracted waste management company disposed of the unwanted medicines. Medicines were not always disposed of safely as we were told that on one occasion morphine sulphate liquid was poured down the sink by the nurse.

We saw that PRN protocols were in place for some when required medicines, however staff did not keep a running balance of these medicines to ensure that there was enough stock available.

An incorrect record was made of one dose of warfarin given to a person using the service. This recording error had not been identified by the registered manager or the provider.

When we reviewed the medicines records we saw that although there was evidence that people were receiving their medicines as prescribed, some of these records were not completed fully. For example, when people missed a dose of their medicines, the reason for this was not always clearly documented. However, when medicines with variable doses were prescribed (for example, one to two tablets for each dose), staff recorded the actual dose given on the MAR chart.

It was difficult to ascertain whether people's medicines were reviewed by the GP on a regular basis, or whether there was input from other specialists for example, the community diabetes nurse.

An administrator facilitated the delivery of training around medicines to all nurses and Health Care Assistants (HCA). The Age Care Channel (ACC) was the training provider used by the care home. Most of the medicines training sessions were delivered using a DVD. The administrator then facilitated a discussion on the topic covered. If there were questions that the administrator was unable to answer, internet search engines were used to assist with this, for example .gov or .nhs websites. There were no signatures seen to prove that staff working at the home had read and understood the provider's medicines policies. There was no evidence seen of medicines related training or competency checks.

This evidence showed people's medicines were not being managed safely, and people were not always receiving their medicines as prescribed.

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

We were told that there was lot of medicines waste each month because of the previous medicines reordering system; however a new system had recently been implemented to resolve this.

The MAR charts were generated by computer by the local community pharmacy. There were some handwritten MAR charts in use during the inspection, but these were for people who had been newly admitted to the care home.

We reviewed 17 medication administration record (MAR) charts during this inspection. We saw that allergy statuses were clearly documented for each person. 16 people had a recent photograph filed with their MAR chart.

The provider did not manage risks to people using the service. Some of the care records we saw did not include assessments of possible risks to people using the service or guidance for staff on how to mitigate risks. Where staff had completed assessments of possible risks, they did not always put in place plans to make sure people were cared for safely. For example, we saw risk assessments for two people that showed they were at high risk of falls and developing pressure sores. However, staff had failed to act on the results of the assessments and there were no risk management plans in place or guidance for staff on managing the identified risks. We also saw an incident report where a person had an unexplained bruise. The incident report was hand-written and identified the wrong members of staff who had reported the bruise. The person's file did not include a body map showing the location and extent of the injury and there was no risk assessment to identify possible risks to the person and provide staff with guidance to mitigate these.

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

People may have been at risk of unsafe care as the provider did not deploy staff effectively to meet people's needs. A relative commented, "There are times when people are left in the conservatory and there are no staff around for quite a long time." A person using the service commented "There can be a problem when 2 people need the toilet at the same time." A member of staff told us if all the staff were in then there were enough staff but when someone was off sick then that caused problems with shortages of staff. A second member of staff said "weekend staff shortages are more of a problem and at night there can be a problem"

People also told us they sometimes had to wait for care and support. One person said, "I might have to wait half an hour for a response to the call bell." A second person told us "There is a delay with the call bell sometimes at night." However, a third person said they had only used the call bell once and the staff had responded quickly.

During this inspection we saw there was sometimes a shortage of staff for the number of people using the service. Although there were volunteers assisting in the communal lounge, staff were often not present as they were assisting people with personal care, feeding or transfers on other floors. Elsewhere, people who chose to stay in their rooms were isolated as there was often no member of staff available if they needed assistance.

Staff rotas showed that a registered nurse was on duty at all times, supported by Health Care Assistants (HCA) and volunteers. During the day the rota showed three HCA's were usually on duty in the morning and three in the afternoon and evening. At night, there was one nurse and two HCA's on duty.

However, people using the service, staff and relatives told us that there were times, especially at weekends, when there were not enough staff on duty due to sickness. They told us this meant people had to wait for care and support on occasion. As part of this inspection, we made an unannounced visit to the service on a Sunday morning. We found the provider was in the home with a registered nurse, four HCA's, two domestic staff and the cook. This level of staffing was reflected in the rota for the day and we did not see people waiting for staff to support them.

The staff rotas showed one nurse had worked 24 days without a day off. We discussed this with the provider and registered manager who told us this had been necessary as there were not enough nurses employed to cover the rota. The provider had not taken action to employ a qualified agency nurse to support the permanent staff and cover shifts on the rota and this may have placed people at risk of unsafe care.

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

2014.

People using the service and their relatives told us they usually felt safe using the service, although some commented on the lack of staff on occasions. Relatives told us, "I'm happy my [relative] is safe when I'm not there" and "I have no concerns about my [relative's] safety." One relative did comment, "There may be a safety issue when there are not enough staff to help people, but generally they seem to manage quite well." A second relative told us, "There are times when there are not enough staff to supervise people."

At our last inspection, we found the provider had not carried out some checks on new staff working in the service. The provider sent us an action plan and said they would complete the required checks by 20 September 2015. During this inspection we checked the staff recruitment files for eight nurses and health care assistants who worked in the service. We saw each file included an application form and employment history and the provider had obtained references and carried out Disclosure and Barring Service (DBS) criminal records checks for all staff.

At our last inspection we also found the provider did not respond appropriately to possible safeguarding incidents as they did not report these to the local authority's safeguarding adults team and had failed to notify the Care Quality Commission (CQC). At this inspection we found the provider had notified the local authority of four possible safeguarding incidents and had cooperated with the local authority's investigations. The provider had also notified the CQC of each incident.

Staff we spoke with were all able to provide definitions of different forms of abuse and all said they had received training in safeguarding. They said that they were confident of the procedure to follow if they had a safeguarding concern and told us they would report to the nurse on duty or the registered manager. However, not all staff were aware of who to contact outside the home if they wished to report an alert and none were aware of the legal protections offered to whistle blowers.

We recommend that the provider ensures all staff are familiar with the pan-London Guidance on safeguarding adults, the London Borough of Ealing safeguarding adults procedures and the Public Interest Disclosures Act 1998.

Requires Improvement

Is the service effective?

Our findings

Staff did not receive the training they needed to provide safe and effective care and support for people using the service.

Staff training records showed most staff had completed training the provider considered mandatory. This included, manual handling, safeguarding adults, medicines management and assessing risk. We saw no evidence the provider had checked staff understood the training they completed and applied it to their daily work. The provider's training system required the registered manager to sign off each completed course and competency assessment and review this during supervision. However, the registered manager had not fully completed the training records to show they had discussed the training with staff and had not completed all competency assessments.

One member of staff said they "had lots of training initially with a trainer, and had been paid for it, but there is less now." Although other staff told us they had completed training, some we spoke with were unable to demonstrate an understanding of the Deprivation of Liberty safeguards or provide definitions of mental capacity / best interests decisions. Some staff felt that training was less effective than previously as it was mainly delivered via DVD with no practical follow up or supervision to ensure that the training had been effective and fully understood. Staff also commented that they were not adequately trained to manage some residents with high levels of need, particularly challenging behaviour and mental health needs.

We saw no evidence staff received regular supervision or an appraisal of their performance. Staff reported that although in the past there was a system of personal review and appraisal, this no longer occurred. Although there were occasional group meetings these were not regular and did not provide a suitable forum to discuss personal performance and issues. There was therefore little or no opportunity for staff to discuss their role, training needs, personal development or concerns. In the staff records we checked we saw one person had an annual appraisal in 2010, 2011 and 2012 and supervision twice in 2009. Two other staff files contained no record of supervision or appraisal.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) 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.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Consent to care and treatment was inconsistently documented or absent in some of the care records we

reviewed. In some records, the person using the service, their family member or other representative had signed the care plan. There was no evidence the provider had checked that relatives had Lasting Power of Attorney in health and care matters that allowed them to consent on behalf of the person using the service. There was no other evidence of consent to care and treatment.

Staff told us that if a patient refused to take a medicine, the nurse would give them some time, and offer the medicine again. If the medicine was refused again, the nurses would crush the medicine into the patient's food or drink and administer it covertly. There was no evidence that best interest meetings had taken place to discuss whether covert administration was in the best interests of any person.

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

There was some evidence the provider had carried out assessments of individual's capacity to make decisions. In most cases, the GP had recorded their discussion of Do Not Attempt Resuscitation (DNAR) forms with people using the service and their relatives. Three of the four DNAR forms we saw were correctly completed and had been correctly authorised by the GP. One form was not completed correctly and the section on capacity had not been completed.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager understood their responsibilities in relation to MCA and DoLS. They told us they had sent three applications to the local authority for approval and they planned to send others. The local authority had not yet approved the applications sent by the registered manager.

Comments from people using the service and their relatives about the food provided in the service were mixed. Comments included, "The food is perfectly adequate but I wouldn't say it was inspired." This person added the lunches were reasonable. "The food is A1." This person added there was some choice and they were offered seconds. "The food is OK," "The food is good, My [relative] quite likes it. It seems home-cooked," "The lunches are OK," "The food is a bit monotonous, it's the same things" and "Overall the food is not good, occasionally you get a good meal." Another relative said there was a choice and seconds were offered. And if the resident didn't want what was on the menu they would make something else. He also said that the staff were always offering tea and biscuits. "The portions are reasonable, but more like a dietician's size rather than domestic sized. There are a lot of potatoes."

One person said the suppers were quite boring and always the same: a bowl of soup and two little squares of sandwiches. They added that no-one ever asked them about their food preferences. A relative said "Tea time is unexciting, soup and a couple of sandwiches."

Care records showed people accessed the health care services they needed. Care plans and daily care notes recorded people's appointments with their GP and other health care professionals.

Staff weighed people every month and recorded this in a separate book. This was up to date. Care records included a separate care plan area dedicated to eating and drinking which recorded dietary needs in some cases such as the need for fortified or pureed food, swallowing difficulties and assistance required to eat and drink. One care plan noted a referral to the dietician in the monthly evaluation but the care plan had not been updated to reflect the advice supplied.

Staff recorded nutrition risk assessment scores for each person and updated these monthly. However, not all records were fully documented and some only showed weights with no regular review of the risk assessment. The nutrition folder recorded the food eaten by each person on a daily basis. However, this only recorded what food had been served but not the quantity consumed. Some people had their fluid input / output monitored in a separate file and this was up to date and well completed showing input volumes across each day for each person monitored.

Requires Improvement

Is the service caring?

Our findings

People using the service and their relatives told us most staff were caring. Their comments included, "The staff are patient and caring," "They do have some caring staff but there has been a high turnover," "The staff are excellent. They don't ask too much of you. They're very very good and patient. They want to help you. They do their best for you and they know what is right for you. You're not just a case, that's a fact. You can talk to some staff and they are sympathetic listeners," "The staff are very nice and friendly," "The carers are mostly OK. They are extremely cheerful and friendly." One person did comment, "The staff are caring. The nurse is a bit aggressive, she shouted at me one day, and I told her there was no need for her to shout at me. One of the other nurses told me she gets a bit worked up."

Comments made by people's relatives were also varied. They told us, "Everyone's very nice, very friendly," "The staff are very nice. My [relative] gets on with everyone," and "The staff are very caring."

Other relatives said, "Certain staff are very brilliant, but some other staff could be a bit grumpy at times," "There are tensions between staff sometimes and we have raised this with [the provider]," "Some staff are better than others and it is clear they don't all get on" and "The staff are caring, some are great. You could improve the soft skills of the carers."

During the inspection we saw that most staff were gentle and patient and took time to speak to people and understand their wishes. Staff we spoke with were familiar with people's needs and routines and were able to explain the care and support different people required.

However, at times there was no personal interaction between residents and staff and no attempts made to engage with or converse with people either in communal areas or with individuals in their rooms, except when delivering personal care or assisting with meals. During the first day of this inspection, all four members of the inspection team observed a significant variation in the atmosphere in the home between the morning and afternoon. In the morning, staff had little interaction with people using the service or each other. In the afternoon, staff were much happier, talking with people and each other, smiling and welcoming.

Staff said they always respected privacy and dignity by ensuring they respected people's choices and closing doors when delivering personal care. During the inspection we saw staff knocked on people's doors before entering their rooms and provided privacy when supporting people with their personal care. Shared rooms had screens to enable staff to provide some privacy when both people were in the room.

The care records we saw mainly covered people's health and personal care needs and we saw little evidence people were involved in planning the care and support they received. The care records included little information about people's life histories or background although a booklet had been included in new care files for this purpose. However we saw only one that a person's friend or relative had completed. Daily care notes completed by staff mainly covered people's personal care needs and there was little mention of visitors or activities.

Staff did not support people to move around the home and did not offer choices about what they wished to do. Most people remained in their rooms or in the communal lounge / conservatory all day, although a film was shown on the first day of our visit. Some people who were unable to mobilise were left unattended for periods of time and those who chose not to come to the communal lounge were isolated in their rooms for the day, dependant on visitors for any conversation or company.

Requires Improvement

Is the service responsive?

Our findings

The provider's care planning systems did not provide sufficient information about people using the service, their care and support needs and how the service would meet these. Staff told us the provider was changing the home's care planning system with support from external consultants. During the inspection we looked at the home's existing system, as well as the new system that the provider planned to introduce.

Records of each person's continued care and support were not always maintained. Existing care plan files were poorly maintained, disordered and very difficult to navigate which meant it was difficult to track peoples' progress or care or identify staff responses to changes in need or risk. There were separate care plans for different aspects of each person's health and personal care. These included mobility, eating and drinking, elimination, skin integrity and pressure care. Although there was some evidence of person centred planning and individual preferences and routines such as personal care choices and sleeping routines, the care plans were handwritten and poor legibility made it difficult to decipher people's needs and preferences in some cases.

The provider's procedures required nursing staff to review each care plan area monthly but they had not reviewed some of the care plan areas since October 2015 or earlier. The registered manager acknowledged this and said that there had not been time to update records. Most monthly evaluations did not contain sufficient detail and did not always record other documented changes e.g. weight loss, wounds or falls. One resident had a history of aggressive behaviour and self-harm although there was no clear behavioural management plan or record of progress or assessment.

Staff maintained a separate form in each file recording personal care. These were up to date and staff used codes to indicate the personal care support they provided each day. However, the records we saw showed only body washes each day so far in 2016 and we did not see any evidence of any person having a bath or shower, although one of the care plans indicated that the person liked a weekly shower. We also saw many of the bathrooms in the service were used for the storage of equipment and did not provide a comfortable environment for people who wished to have a bath or shower.

Staff also completed daily records of the care and support they gave people using the service. These were up to date in the files we reviewed. However, most of the daily notes lacked sufficient detail and were mostly generic and repetitive, covering only personal care tasks. Again poor legibility meant that it was not possible to read some of these records.

The new system of care plans / records staff told us the provider was introducing was not yet fit for purpose. Most of the care records had not yet been completed and we saw no detailed care plans or risk assessments in these files. Each file included a list of contents at the front, although some files were not ordered correctly. One file was completely empty and contained no information about the person or their care and support needs. Each file included a 'This is me' – pen picture booklet with personal history / background, details of family, past employment etc. Only one of the six booklets we reviewed had been completed.

Two records contained a Threen House initial assessment form. These had some personal details e.g. DOB, contact details for GP / next of kin and a tick box check list for 21 different aspects of care to indicate level of need e.g. communication, continence, mobility, skin integrity etc. However the assessments lacked detail and there was no assessment of risk or the support each person required. Two of the files we saw contained details of a care plan audit by the Clinical Commissioning Group's quality assurance nurse advisor. The audits highlighted a lack of or inadequate risk assessment or review, lack of or unsafe care planning, lack of consent and lack of regular monitoring. This reflected the concerns we had about the provider's care planning systems.

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

People using the service and their relatives told us there were some activities organised in the home, but not every day. Their comments included, "There is entertainment every other Tuesday. Tuesday is the activity day." This person also mentioned carol singers had been before Christmas. They said they were normally told on the day what the activity would be but they had not received a print out of activities. A second person also mentioned films every other week, and someone coming to play the keyboard every other week. They told us there had been two sets of carol singers and a Christmas Party on Friday the week before Christmas. They also said there had been an outing to Syon Park in July and no outing since then. "The activities are fairly limited e.g. once a week we have films or music."

A relative commented, "There are some activities once a week e.g. music, exercise classes." This relative also said, "It would be helpful for someone to tell my [relative] about the activities."

Another relative organised and ran a film show every other Tuesday and we saw this took place during our inspection. The provider told us a group of relatives met every three months to organise fund-raising events, and all the activities, including the Summer Tea and Christmas parties, trips to Syon Park and Kew Gardens.

However, the service did not have a dedicated activities coordinator and we saw no clear records of engagement in the daily life of the home or the hobbies people enjoyed. There was little to engage or entertain people on the days we visited and most people remained sitting in chairs in communal areas or in their rooms. Many people remained inactive through the day and those who remained in their rooms were left isolated without any communication/interaction beyond staff providing personal care or meals.

Care records included a section to record social activity which consisted of a coded form so that daily activity could be recorded. These forms were all mostly blank and there was no meaningful detail about engagement in the daily life of the home, behaviour, mood or interaction with others. When we asked care staff, they said they had not had training on the provision of meaningful activities for older people and did not have time to spend any significant time interacting or conversing with people beyond their physical care duties. A relative commented, "Personal care is good, but staff are not encouraged to interact with residents."

At our last inspection, we found the provider did not record, investigate or respond to complaints made by people using the service or their relatives. Following the inspection the provider sent us an action plan and said they would improve the way they managed complaints by 30 September 2015. At this inspection we found the provider had improved the way they recorded and investigated complaints. People using the service and their relatives told us they knew how to make a complaint and said they felt the provider would take these seriously. Their comments included, "My room was cold and the minute I mentioned it, something happened and they brought an extra heater." Two other people and three relatives all told us

they had no complaints. One person did say they had no complaints about the nursing care but had complained about the food and nothing had changed.

We recommend that the provider refers to guidance on the provision of meaningful activities for people living in care homes.

Inadequate

Is the service well-led?

Our findings

When we arrived for the first day of the inspection, we saw that the provider had not displayed the service's Inadequate quality rating from our last inspection in July 2015. We discussed this with the provider as we had noted at the last inspection that the overall Good quality rating we awarded following the inspection in February 2015 was displayed on a notice board in the hallway of the service. The provider told us the last inspection report was included in a folder of information on a table in the hallway and this included the quality rating. Our guidance for providers states "We expect that you will display your poster at the main entrance to the home and/or where as many people as possible are able to see it, including people who use the service". Providers do not have to use the rating poster available from the Care Quality Commission (CQC) but the rating must always display the most up-to-date ratings and must be displayed legibly and conspicuously to make sure the public, and in particular the people who use services, can see them.

This is a breach of Regulation 20a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider carried out some checks to monitor the quality of the service provided, these were not always effective. For example, people's care plans were not always regularly reviewed, staff training was not evaluated, there was no supervision or appraisals for staff and we found evidence of poor medicines management practises. None of these issues were identified by the provider as part of their monitoring of the service.

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

We received some negative comments from people using the service and their relatives. These included, "Sometimes the registered manager does not act in a professional manner. She can be quite outspoken and critical of staff in front of staff and residents. This may impact on morale and may have an impact on service delivery However, I have only occasionally witnessed this behaviour. [Registered manager's name] can also be pleasant, personable and supportive" and "[The provider] cares that it's clean, it's private and he cares that patients are clean. There was a better team before, now the atmosphere is worse. We have to show new people, they come for a week's training and don't stay, they don't pay enough. Some people don't want to work and other staff get annoyed."

Several staff commented that some senior staff behaved in an inappropriate manner, shouting at care assistants in the presence of residents and other staff which was distressing for residents, demotivating for staff and created a bad atmosphere in the home.

Members of staff we spoke with also said morale at the home was low due to the high turnover of staff and shortages of staff, especially at weekends. They claimed that they were not well supported by senior staff or management and that the home lacked a culture of openness and transparency. In particular, some mentioned that there had been an inadequate response to recent safeguarding concerns and that staff had

not been suitably informed about events or outcomes. They stated that they did not have any opportunity to discuss their work, individual performance or problems with management which had resulted in resentment, distrust and a reluctance to raise concerns.
Other people using the service and their relatives told us they knew who the provider and registered manager were. Their comments included, "[Provider's name] is very good, he's in charge of this place." "[The provider] is great, caring, responsive and supportive," "They communicate very well, it's a good relationship," "[The provider] is a friend and an ally," "Things work well when [provider's name] is here, but people seem impatient with others; there wasn't the supervision one would expect," "[The provider] is very conscientious. If he were here all the time every time that would be perfect. He stands in and helps out," "[The provider] does a great job and it generally reflects down through the staff. He leads by example. If every home had a provider like him we'd be in a much better situation. He's very caring, he can't do enough, he treats everyone like his own. He sets the standard by his own behaviour. Good leadership" and "[The provider] does a good job." Another relatives commented in a letter to the provider, "The building itself is very attractive, and [relative's name] spent many hours in the conservatory, looking out onto the lovely garden. Your 'Visit Any Time' policy reassured us that the residents were well cared for, at all times, and that you and your staff had nothing to hide. We appreciate being made welcome to visit [relative's name] at any time including meal times, and enjoyed well cooked meals with the residents and staff."

Some of the checks and audits the provider completed were up to date. For example, gas and electrical safety checks were up to date, the provider checked and recorded hot water temperatures throughout the service in December 2015 and January 2016, fire safety checks were up to date, the annual lift service was completed in May 2015 and the provider confirmed all required work had been carried out, and daily room checks were carried out and recorded to show repairs and maintenance work that was needed.

The provider sent quality surveys to people using the service and their relatives in May 2015. 93% of people who responded rated all aspects of the service as 'excellent'. 7% of people rated all aspects of the service as 'good'. Nobody rated any aspect of the service as 'fair' or 'poor'.

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 did not take formal enforcement action at this stage. 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 The care and treatment of service users did not always meet their needs or reflect their preferences. Regulation 9 (1) (b) and (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not always provided with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not managing medicines safely. Regulation 12 (2) (g). The registered person did not do all that is reasonably practicable to mitigate risks to service users. Regulation 12 (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The service provider did not display at least one sign showing the most recent rating by the Commission that related to the service provider's performance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of suitably qualified, skilled and experienced persons deployed to care for service users. Regulation 18 (1) Persons employed in the service did not receive appropriate support, training, supervision and appraisals to enable them to carry out the duties they were emplotyed to perform. Regulation 18 (2) (a).