Handsale Limited

Handsale Limited - Silver Trees

Inspection report

Brockway
Nailsea
Bristol
Avon
BS48 1BZ

Tel: 01275859556

Date of inspection visit:
18 February 2016
19 February 2016

Date of publication:
13 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 18 and 19 February 2016. Silver Trees provides accommodation and nursing care for up to 62 older people.

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. Residential care was provided on the first floor and nursing care on the ground floor.

Medicines were being administered by qualified nurses and by senior healthcare assistants, but competencies which should have been checked annually, were not available. As a result of our concerns, the registered manager arranged for agency nurses to cover shifts until the necessary competency checks could be completed.

People who were at high risk of developing pressure ulcers were using air mattresses which were not set correctly, thus increasing the risk of developing pressure ulcers. Gaps in wound care plans meant there was no information to show whether a wound was healing or deteriorating or what treatment had been provided, and people may not have received the care and treatment they needed as a result.

Several records contained contradictory information. For example care plans said people needed both a pureed diet and a normal diet, which meant the person could have been given the wrong type of food. Care plans from the nursing unit did not provide staff with enough detail about people's individual needs and contained limited personal preference details.

Staff rotas showed there were days when staff numbers were short. People were complimentary about staff and said they were very kind and considerate. Not all staff had received training in how to recognise and report abuse. However, all staff we spoke with had a clear understanding of what may constitute abuse and how to report to the registered manager or a senior. There was an effective recruitment procedure for new staff.

Not all staff had an understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. A nurse and a team leader had signed one bed rail risk assessment used to authorise the use of bed rails. This is poor practice because the process to protect people from unauthorised restraint had not been followed, which meant the person was effectively deprived of their liberty.

People said they were supported by kind staff who respected their privacy and dignity.

Although staff would report any complaints to the nurse on duty, staff had not learned from previous

complaints. Audits had failed to identify the concerns we found, such as the unsafe practice around medicines, lack of consent and incorrect settings for air mattresses. Audits of records had not identified the gaps in records or the lack of information for staff in care plans.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not managed safely because staff did not have the necessary competency checks completed.

People were at risk of developing pressure ulcers because air mattresses were not set at the correct settings.

People were at risk choking because they may be given the wrong texture food; this was because records contained contradictory information. There were several gaps in records which meant staff did not have the information to provide the support people needed.

People said there were not enough staff on duty. We saw there were days when people were not supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner and staffing levels may not have kept people safe.

Is the service effective?

Requires Improvement

The service was not effective.

Although some staff were aware of the principles of the Mental Capacity Act, they did not make sure people's legal rights were protected.

Staff had not received up to date training for subjects the provider had identified as mandatory. This meant people were at risk of being cared for by staff who may not know current legislation or guidance.

People were supported to have sufficient amounts to eat and drink.

Is the service caring?

Good

The service was caring.

People said they were supported by kind and caring staff. We saw staff treated people with kindness and courtesy and people

responded well to staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not have enough detail about people's individual needs to respond fully to them and care plans contained limited information about personal preferences. People said they had to wait when they called for assistance.

Although staff would report any complaints to the nurse on duty, staff had not learned from a previous complaint about people not being able to see their TV screens.

Relatives told us they were involved in care planning and people were supported to maintain contact with friends and family.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality audits did not always pick up shortfalls in the service meaning the provider was not always responsive to changes required.

Several records, such as the nursing dependency tool, contained incorrect information which could put people at risk. Emergency information was out of date, which meant people would not receive the support they needed in the event of an emergency.

There were meetings for people who lived at the home and their relatives, which gave everyone the opportunity of providing feedback to the home. Several groups of people took part in satisfaction surveys which included relatives, internal staff and professional visitors.

Handsale Limited - Silver Trees

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 18 and 19 February 2016 and was unannounced. It was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed information we held about the home, including notifications about important events which staff had sent to us. We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The provider therefore provided us with a range of documents, such as copies of internal audits, action plans and quality audits, which gave us key information about the service and any planned improvements.

During the inspection we spoke with 15 people using the service and six relatives about their views on the quality of the care and support being provided. We spoke with one visiting healthcare professional. We also spoke with the registered manager, the residential unit manager, the clinical lead and six staff including the cook and activity leaders. We spent time observing the way staff interacted with people and looked at the records relating to care and decision making for eight people. We looked at records about the management of the service including four staff files and the quality assurance file.

Inadequate

Is the service safe?

Our findings

People's medicines were not managed safely because the provider did not have a system in place to monitor and review the competence of staff who administered medicines. Although staff had received further training for administering medicines and undergone supervision sessions, no formal medication competency assessments had been completed. The provider's Medicines Policy and Procedure stated "Care workers, including registered nurses, who administer medicines must be trained in the handling and use of medicines and have their competence assessed" and "Each staff member will have an individual record of medicines training, competence assessment and practise skills supervision monitoring". Medicines were being administered by qualified nurses and by senior healthcare assistants, and although the manager said they reviewed staff competencies annually, when we asked to see these there were none available. This meant the provider was not able to show us the competencies checks had been undertaken and what the results were of these checks.

The registered manager said some staff administering medicines had not been in post for a year which was why the competencies were not in place. However, the provider's medicines policy stated "Certification of previous medication training must be supported by competence assessment of the staff knowledge and ability to manage and administer medication before staff are permitted to undertake medicines handling". This meant the registered manager was not following the home's policy and procedures and consequently staff had not been assessed as competent to administer medicines before they were able to perform the role unsupervised. As a result of our concerns, the registered manager arranged for agency nurses to cover shifts until the necessary competency checks could be completed.

We found one staff member had made a second medicines error, which the registered manager was not aware of. A medicines error had occurred during January 2015 and a full investigation had taken place in conjunction with the pharmacy that provided medicines to the home. A member of staff gave person A person B's tablets and vice versa. The first time this happened the incident was investigated and the member of staff underwent eight supervision sessions before being able to do medicines alone again. However, the supervision records raised issues such as leaving the trolley unlocked in the corridor, leaving tablets with people without ensuring they had been taken but signing the MAR to say people had taken their medicines and not offering pain relief because they didn't think people needed it. The member of staff was not formally assessed as competent; there was no competency form in place. This meant the registered manager had not followed the homes medicines policy and as a result, the member of staff should not have been administering medicines. One person's medicines were still in the medicines blister pack from 12 February 2016, although the medicine administration record (MAR) chart had been signed to indicate the medicine had been given. Three members of staff had noted this on the Medicine Administration checklist, but had not reported it as a medicines error. This meant staff had not understood their responsibilities in relation to managing medicines, despite having refresher training. Although nurses checked the medicine administration records, and checked that medicines had all been administered, nobody had raised any issues that were noted. This meant medicine errors were not always reported, investigated or learnt from.

The Clinical Lead said that nine members of staff were administering medicines. Staff who administered

medicines were required to sign an acknowledgment they had read and understood the policy and procedures for medicines. Two staff had not signed this. This meant they may not have been aware of the policy and procedures for the safe handling of medicines and people could be at risk of receiving their medicines in an unsafe way.

The provider completed monthly medicine audits and we saw the latest audit completed by the deputy manager dated 25 January 2016. The audit identified non-compliance with stock control, where actual quantity of medicines in stock did not match with the calculated quantity. Other failings identified included medicines not always being administered safely and some medicines were out of date. The form did not detail actions required for all areas of non-compliance; it detailed actions required in relation to stock control and use of homely remedies but did not address unsafe administration or out of date medicines. The auditor had also ticked to confirm that all staff had been deemed competent to administer medicines despite a lack of documentation in place to support this. The auditor had assessed the residential unit as having an overall compliance score of 55%. According to the information within the audit, this meant an "overall fail". The information stated "Should any care home fail their medicines audit, then weekly medicines audits must be conducted until the issue is resolved". These weekly audits had not been completed and the Clinical Lead was not aware of the overall fail status. This meant although audits were undertaken, the actions necessary to keep people safe were not being completed and people were at risk as a result.

Six people did not have topical medicines applied as prescribed. Their records did not give staff guidance about when or how often the creams should be applied. We saw six people's records which showed their creams had not been applied consistently and in line with the guidance from the GP; some days they were applied once, other days they were applied twice; other days the creams had not been applied at all. One person's records showed the cream they needed had not been applied on ten occasions out of 40. The record dated 20 January 2016 said, "course is completed", and yet the cream was subsequently applied again on nine occasions. Other records did not give staff information about where they should apply creams. This meant people did not always receive the care and treatment they needed to manage their health conditions.

Some people were prescribed medicines on an 'as required' basis. We observed one person waited 55 minutes for pain relief; no reason was given to them why they had to wait so long. When medicines which were able to be taken as required had been prescribed the guidance in place for staff was not consistent. The guidance on the residential unit was detailed and informative. The guidance on the nursing unit was not always completed in full and did not provide person centred information to staff. For example, information for one person informed staff the reason for the medicine was "pain". It did not inform staff where the person might experience pain. The maximum dose the person could have was not recorded. This meant there was a risk staff may have missed the signs of pain and appropriate treatment could be delayed as a result. Another person's guidance said a barrier cream should be applied to "sore skin". It did not detail where or how often this should be applied. One form provided incorrect information on the maximum dose of Paracetamol a person could receive. This meant there was a risk the person could be given medicine above the recommended safe dose. One person was able to self-administer a pain relief gel. A risk assessment had been completed, there was a care plan in place and the person had signed the plan to indicate their agreement.

When people left the home for a short period, medicines were not provided safely or in accordance with the provider's policy. When one person was going out for the day, the member of staff removed the sealed lid from the pod of prescribed medicines, added another tablet and then jammed an empty pot into the top in an effort to prevent the tablets falling out. This meant the tablets could easily be lost and the person would

not have their medicines. The provider's policy stated that if people were likely to be out of the home for one or more medicines administration times, they should be given the correct medicines and clear written instructions. The instructions were not provided which meant anyone helping the person with their medicines would not know how to give them safely.

Codes used on the MAR charts were inconsistent because different templates were being used across the two floors. Codes are important to show if people had refused their medicines or medicines had been destroyed. One member of staff signed the MAR chart with the letter "D" which according to the codes on the person's chart indicated the medicines had been destroyed. However, they thought code D meant social leave, which is when people have day trips out. They amended this to the correct code when we pointed it out to them. Staff told us different codes were used on different floors. This meant where codes had been used in the MAR charts, there was no guarantee the codes were correct. The Residential Manager said that new templates were being sent from the pharmacy and all charts would be replaced.

MAR charts contained photographs of people, but these were not always dated. Dating photographs is important because people's appearances can change over time. This meant if old photographs were used staff may not be able to correctly identify people and there was a risk they may be given the wrong medicine if their identity was not established.

The fridges where medicines were stored had daily temperature monitoring records in place and these had been completed and were up to date. The medication rooms also had temperature monitoring logs in place. Monitoring these temperatures is important to ensure medicines are stored correctly. On the residential unit, the temperature had been recorded as over 25 degrees centigrade on 6 occasions between 01 February and 18 February 2016. In the nursing medication room the temperature had exceeded 25 degrees on one day during February. The latest pharmacy advice visit on 22 October 2015 had noted this and suggested the provider consider installing air conditioning within the medication rooms, or a better method of temperature control. Although we saw a quote for air conditioning had been received this had not been followed up. Both rooms had electric fans in place, but the temperature logs showed these were not sufficient to maintain the temperature below the recommended 25 degrees. This meant medicines may not be as effective as they should be because medicines can deteriorate if not stored correctly.

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

Several people using the service had been assessed as being a high risk of developing pressure ulcers. Air mattresses were being used and there were pressure mattress checklists in people's rooms. These were for staff to check twice daily that the mattress was set correctly and in full working order. Air mattresses should be set according to people's weights to be effective at reducing the risk of pressure ulcers developing. Incorrect mattress settings could mean that the skin was not as protected from pressure sores as it should be, and can also mean the person was not comfortable when in bed. We looked at nine mattresses and nine pressure mattress checklists. Five of the charts had a recommended setting documented, the others did not. Only two of the mattresses were set at the required setting. This meant people were at increased risk of developing pressure ulcers. A meeting was called immediately during our inspection and staff were reminded to check air mattresses had been correctly set. People may be at increased risk of developing pressure ulcers because training records showed only 50% of staff had received pressure care training in the last three years.

Although wound care plans were in place, we saw they did not give detailed information. We saw one person had a 'body map' dated 8 October 2015 for a wound and a wound assessment dated 20 and 21 January 2016; however there was no information available between these dates to detail the condition of

the wound or the treatment provided. The lack of records meant it was not possible for the provider to monitor if the treatment provided was the most effective and appropriate to promote healing. Wound plans did not always contain photographs of the wounds which would help different staff to observe for signs of deterioration and improvement. One person had been seen by the district nurse on 15 February 2016 due to a wound on their right leg, but there was no photograph in place. Another person's admission assessment four days earlier made reference to a "Grade 2-3 pressure ulcer on sacrum". The Clinical Lead said this wound was not as bad as the assessor had documented and the person's skin was red but intact. There was no photograph in place to confirm the condition of the person's skin.

Another person's care file recorded they had fallen on 8 December 2015 and daily observations were to be completed. These had not been done. The lack of required observations meant the person's condition was not being monitored and there was a risk the person may not have received any care and treatment they required in a timely way.

Three records contained contradictory information which put people at risk. A document called a nursing dependency tool, which summarised the support people needed, was not using a current list of people using the service. This meant incorrect information was being used for one person which stated they required a normal diet, however other records contradicted this and said they needed a pureed diet. Another person's care plan stated they should have a diet which was very moist and soft; however the care plan also stated they should have their food cut up. This meant people could have been at risk of choking if staff had given them the wrong type of food. One person's care plan contained information about their end of life wishes. This document said two things, "Do Not Resuscitate in place" and "I do not have a Do Not Resuscitate in place." This meant staff would not know the person's preferences and could make the wrong decision about this person's treatment.

The communications book on the nursing floor contained a fax message from a G.P on 16 February 2016 saying they wanted daily blood pressure checks for one person, to be recorded for the next two weeks. The message stated if the readings were high consistently for a few days the G.P was to be contacted. This person's blood pressure had not been recorded on 16 or 17 February, but had been recorded on the day of the inspection. This meant, at the time of the inspection, the GP's request was not being followed and the person may not have received the G.P's attention they needed in a timely way.

Nurses kept nightly reports where they recorded information about wounds and dressings they had applied. We saw several gaps in these records where we would have expected to see information as people's care plans showed treatment should have been given. For example, one person's records had five gaps with nothing recorded, another person's records had two gaps and a third person's records had three gaps. One person's records did not show what staff had done when skin cracks and sores were found. Another person's care plan recorded they had complained of chest pain, however there was nothing further recorded. Many forms in care plans were not dated or signed by the person who completed them. This meant there were risks that people had not received the care and treatment they needed and accurate records had not been maintained.

In the event of an emergency occurring, staff had access to information files about what support people would need to be able to evacuate the home safely. We saw this did not contain an up to date list of people using the service. On the ground floor, four people did not have emergency evacuation plans and another plan did not have the correct person identified. This meant five out of 22 people may not receive the support they needed to be able to evacuate the home. On the first floor, one person's evacuation plan did not match the information in their care plan. Their care plan said they needed to be moved using a wheelchair, yet their emergency evacuation plan said they could move slowly with a wheeled trolley.

Training records showed only 7 out of 41 staff had attended fire safety training in the last six months. Records showed 65% of staff had attended fire drills in the last six months. The registered manager told us fire drills were carried out weekly, although they were required monthly. This meant records were not updated with current information.

The business continuity file did not contain information for staff on how to manage the service in the event of large scale staff sickness, adverse weather or other emergencies. This meant in the event of such an occurrence, there was a risk there may be insufficient staff numbers to provide care and support to people using the service.

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

People said, "Nothing is too much trouble for staff but we could do with more staff." We saw staff rotas which showed there were 12 staff on late duty in total one day, and the following day there were 15 staff for the same shift. Another rota showed there were 10 staff on early duty one day and 12 staff for the same shift the following day. Many of these staffing numbers were made up of agency staff; however the agency staff were used regularly. Staff said, "Agency staff are very good, they're the same as permanent staff", "Sometimes we're not short. We can give good care when we have time" and "It should be five staff to 30 people, today we're four to 31." This meant there were days when people were not supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner and staffing levels may not have kept people safe. The registered manager told us, "We have a dependency tool which uses information from care plans to calculate the staffing levels required". The dependency tool gave a summary of the support people needed, but did not explain why there should be any variances in staff numbers.

People had a call button within reach while they were in their own rooms; however they said they usually had to wait for staff to respond. People said, ""I feel safe enough but they do not always come as quickly as I like, staff are always busy" and "When I press my buzzer they take their time, they do not exactly rush". Other comments included, "I would love staff to sit and talk to me but they are too busy"; "Plenty of staff about but they're always rushing" and "These areas usually have enough staff on duty, but I feel at times it would be better if there were more". Relatives spoken with felt their relatives were safe, although one said, "There is always a staff shortage and it is not unusual to have to wait for 30 to 60 minutes for attention, there is also a great turnover with overseas younger staff, who do not understand the needs of the residents."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff told us, and records seen confirmed that not all staff received training in how to recognise and report abuse. Training records showed 57% of staff had received this training. However, all staff spoken with had a clear understanding of what may constitute abuse and how to report to the registered manager or a senior. Staff understood their responsibilities around whistle blowing if this was necessary. Some staff were unaware of the relevant procedures for reporting to the local authority if this became necessary. Staff said, "I'm not sure who to escalate concerns to but would phone CQC."

All staff were confident that any concerns reported to the registered manager would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

Risks of abuse to people were minimised because there was an effective recruitment procedure for new staff. We looked at four staff files which showed the necessary checks had been completed to make sure

they were safe to work with vulnerable adults. Staff files also contained information about their qualifications and employment history. Staff confirmed they had not been able to start work until the necessary checks had been completed.

A range of information booklets was available to staff to provide guidance, such as codes of professional standards and conduct and how to raise concerns. This meant staff were able to look up how to deal with some situations if the registered manager was not available to ask.

We saw agency staff were given an induction which included fire safety, medicines, accident forms and care plans. Relevant qualifications and the agency staff's suitability to work with vulnerable adults was also checked.

There was always at least one nurse on duty on the nursing floor. Every shift had either a care team leader or a senior care assistant on duty as well as a nurse. The registered manager was available weekdays and clinical managers were available every day. This meant staff had access to management level advice and guidance at all times because either the deputy manager or the registered manager were also on call during the night.

People told us they felt safe at the home and with the staff who supported them. People said, "I am happy enough here and feel quite safe; nobody bothers me" and ""I feel very safe here, I don't have any worries. If I did, I would tell my family." One relative said, ""My relative is completely safe, happy and well looked after". Staff told us, "Everything is ok" and "If I have a problem I say so."

Requires Improvement

Is the service effective?

Our findings

While some staff had an understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected, other staff we spoke with did not. 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. Staff who did not fully understand the MCA told us, "Mental capacity is when someone can speak good" and "When a person is able to think correctly and communicate well."

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). Information about DoLS was available at the nurse's station. Staff told us, "DoLS is when someone is forced to stay here" and "I've heard of it." Training records showed 55% of staff had received mental capacity/deprivation of liberty training in the last three years.

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. One person had a deprivation of liberty authorisation in place and the correct supporting documentation was available. There were no conditions attached to this document.

We saw a file which contained some mental capacity assessments. However, these were not decision specific; instead one form was used for multiple decisions. Staff had not completed any capacity assessments for the use of bed rails. A nurse and a team leader had signed one bed rail risk assessment used to authorise the use of bed rails. This is poor practice because the process to protect people from unauthorised restraint had not been followed. We asked staff about the use of bed rails and whether people had consented to them being in use. The staff we spoke with did not understand that mental capacity assessments and best interest decisions needed to be completed. However, we saw a best interests meeting had been arranged for the following week in relation to the use of bed rails for one person. This meant consent to the use of bed rails was not consistently being sought in line with legislation.

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

People received care and support from staff who did not have the skills and knowledge to meet their needs. We saw the current training records which showed the average number of staff who had completed training the home identified as necessary was 53%. Records showed and staff confirmed they had not been given specialist training for conditions such as Schizophrenia or anxiety, although there were people living in the home with these conditions.

People were supported by staff, 33% of whom had undergone an induction programme. The induction

records covered topics identified by the nationally recognised benchmark in place at the time. We saw four staff induction records which showed much of the training had been signed off on one day. The induction topics were supposed to take three months to complete according to the induction standards used. This meant it was not possible to be certain the members of staff had been given the appropriate induction training. One member of staff had started induction in 2012 but the records did not show they had completed it. The registered manager showed us a blank file of the new induction requirements, which they said will be used for new staff. The registered manager told us staff now received a two week induction timetable which included shadow shifts, where new staff were able to observe experienced staff. They said, "Staff are not put on the floor until they are signed as competent."

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

People's nutritional needs were assessed to make sure they received a diet in line with their needs; however their wishes were sometimes ignored. One person was assessed by a specialist who recommended using a named product to thicken their drinks; this meant they were able to swallow safely and the product was palatable. The home ignored the recommendation for this person and used a different product, which the person didn't like. People said, "I have problems swallowing so have soft food, I eat what I am given and do not get a choice", "I like most of the food, especially the fish and chips, it is always hot" and "Food is lovely, I eat everything. I have never had anything I do not like". One relative said, "I am happy with the quality and variety of food, the chef is good, and will cook something different if they do not like what is on the menu".

People were supported to have sufficient meals and drinks. People who had been assessed as having complex nutritional needs had been referred for specialist advice to the speech and language therapist and/or dietician. When people were having their food and fluid intake monitored, food and fluid charts were completed in full and were up to date. There was clear guidance for staff how to escalate any concerns in relation to how much people had eaten or drunk during a 24 hour period. People's weights were monitored at least monthly.

We spoke with the chef who was able to tell us about people's likes and dislikes, any allergies and types of food people ate. They told us they planned the meals with the deputy manager, but they took people's likes and dislikes into consideration when doing the menus. The chef said, "These guys are no different to people in a restaurant. They should still have good presentation and restaurant service. If it looks good, there's more chance people will eat it." Daily food records identified people's food choices for the day. We saw alternatives were available such as jacket potatoes and omelettes. The chef said, "People can have anything. There are two choices of hot meals every day and soups/sandwiches for tea."

At lunch time we saw that people were able to choose where they ate their meal. We observed one member of staff assisting one person to eat. They explained to the person what they were eating and waited for them to finish each mouthful before offering more. Another person who required support to eat was offered their meal in a sensitive and unhurried manner. The member of staff sat next to them and took their cues from the person, allowing them time to eat the food at their own pace. We saw the home had received a food hygiene inspection in March 2015 and had been awarded five stars. This meant the service had been given the highest rating possible.

The chef completed quarterly checks when questionnaires were given to people asking for their opinion of the meals served. The questionnaires asked if people were happy with the portion size and the presentation of the food. We saw where people had requested certain foods, for example spicy foods, this had been addressed. The service user satisfaction questionnaire from July 2015 showed 74% rated the quality of food as good, 50% rated the variety of food as good and 58% rated the presentation of food as good. While this

meant the majority of people were happy with the food they were given, there were a significant number of people who only thought their food was satisfactory. Training records showed 52% of staff had received diet and nutrition training within the last three years. This meant some staff may not have the skills to be able to support people's meal time needs appropriately.

Records showed and most staff confirmed they received regular supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. Staff also received annual appraisals, which is an opportunity for the performance of an employee to be assessed over the year.

The care plans showed the home arranged for people to see health care professionals according to their individual needs. However, we spoke to a visiting healthcare professional who told us they had noticed health related problems on four occasions that staff had missed, and they had had to ask staff to call the GP. During the inspection, we saw referrals were made quickly. For example we observed the Clinical Lead arranging a GP visit for one person who had said they were feeling unwell. We saw them inform the person they had called the doctor for them. The Clinical Lead sat next to the person, put their arm around them and offered reassurance. The GP visited the person as requested.

We saw staff responded appropriately to one person whose diabetes was unstable. Staff monitored the person closely, provided additional sweet food and drink when it was needed and arranged for a GP to visit.

Good

Is the service caring?

Our findings

A book was available in reception for relatives to write their comments. There were two comments since September 2015. One said, "A more helpful, compassionate and cheerful team of staff would be difficult to find" and the other said, "Thank you so much for the excellent care you give. [Name} has been in many care homes but the attention they receive here is so good and caring." A file of thank you cards was on display.

Three members of staff had registered as Dignity Champions, this included the registered manager. A Dignity Champion is someone who supports staff to make small changes that help people using services maintain their dignity. People told us their privacy was respected and all personal care was provided in private. People said, ""Staff are all lovely, very discreet and give privacy; I am happy with all aspects of care", "Staff are respectful and considerate". They are given a choice of gender of carer. People told us, and staff confirmed that where people requested carers of a particular gender, this request was respected. Staff told us how they would provide personal care in a way which maintained people's privacy and dignity, including closing curtains and shutting doors. Most people were called by their preferred names, however one person told us, "I wish they'd call me [name], I've been called this all my life."

There were ways for people to express their views about their lives in the home. We saw the maintenance request book contained a request for a bird nut feeder to be attached near one person's window, so they could see the birds. This had been provided.

People said they were supported by kind and caring staff. We saw staff treated people with kindness and courtesy and people responded well to staff. We observed staff joking with people who enjoyed the banter. One person was able to take the brake off and move their wheelchair while seated in it; a member of staff saw this and offered to help. People told us the care they received was good and said, "Most staff are good, but we could do with losing some of them", "Staff all excellent, they cope very well, cannot speak highly enough of them" and "I've had a 'run in' with one, they do not attend any more". A relative we spoke with confirmed this. One person said, "The floor manager is lovely, she makes a fuss of me". Another person said, "I can talk to the unit manager if I'm not happy or if I have any concerns". Relatives said, "We would be devastated if [name] ever left, she is fantastic", "We are very lucky to have her" and "The unit manager is lovely, she makes every resident feel special". A member of the catering staff did tea and coffee rounds and replenished water jugs in people's rooms on both floors. This person was very cheerful and had a little chat with people as they were being served.

People were treated with kindness and compassion by staff. Staff said "I like this job, and the residents" and "I really like it working here". For example one member of staff said "I always call one person Sir, because I know they used to be in the army. It shows I respect them".

People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private.

People were able to personalise their rooms and had their own furniture if they wished. People made

choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. People said, "I can decide when I get up or go to bed, and can please myself what I do during the day" and "I please myself what I do, I stay in my room from choice". Relatives said, "I like the fact that residents do not all sit around in communal area and can visit friends in other rooms and socialise together."

People we spoke with confirmed staff always knocked before entering their rooms and asked them before carrying out any intervention. They said staff asked them what they would like to wear and held up two outfits for them to choose from. A relative told us staff were very good at helping their relative select clothing and would put make-up on for them because this was important to them. Staff said, "I ask the ladies if they want help to put any makeup on, how they would like their hair styled etcetera. I always ask the men if they want a shave so they look smart". Another member of staff said "I respect people's choices. I only put the TV on in their room if they ask me to, or I will put some of their favourite music on". However, we also observed an inappropriate radio station was playing loudly in the dining room. We asked people if they had chosen the station, and they said "No, it's awful music, please turn it off" and "I can't hear it very well, but what I can hear I don't like". A member of staff turned it off when we asked them to.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. However, one person's topical medication chart informed staff to apply a cream to the person's "nappy area". This inappropriate language had not been challenged by other members of staff.

Although the home had an Equality and Diversity policy and induction topics included Equality and Diversity, staff were not aware of anyone living in the home with needs and preferences around this. Staff said, "I'm not aware of anyone" and "People here are old fashioned." We saw one care plan which documented the support the person needed to follow their religious beliefs. A Church Holy Communion service was held once a month which meant people were supported to follow their beliefs.

Requires Improvement

Is the service responsive?

Our findings

People received care that was not always responsive to their needs and personalised to their wishes and preferences. For example, daily bath records were seen which identified days when people were to be bathed or showered. The records only recorded one person's preference. One person's care plan said they liked a particular drink in the evening; however, when we asked staff, they were unaware of this. Staff told us the person liked a different drink, which had not been recorded in their care plan.

Care plans from the nursing unit were not person centred and contained limited information to assist staff to provide care in a manner that respected people's wishes. They did not provide staff with enough detail about people's individual needs and contained limited personal preference details. Where people had conditions such as anxiety or depression, Bi-Polar Disorder or Schizophrenia, there were no care plans in place to provide guidance for staff how to support the person. We asked staff if they had received training to help them understand these conditions; staff told us they had not received any specialist training. Staff told us they asked people themselves what they wanted staff to do for them and reported any concerns to a senior. This meant there was a risk staff would not know what to do in the event these people suffered a crisis. One person was noted as having communication difficulties due to their medical condition, but the plan only informed staff to "Anticipate needs as communication is limited". There was no guidance about how staff should anticipate the person's needs, or whether communication aids would be useful. This person also experienced chronic pain, and there was no detail of how staff would know the person was in pain if they couldn't communicate it.

The index of care plans did not contain a list of all of the care plans in people's files. For example, one person had a care plan for chronic pain, another person had care plans for skin tears and pressure sores and a third person had a care plan for cognitive impairment; none of these care plans were listed in the indexes. This meant audits of care plans had not picked up differences between the care plans listed in the index and the actual care plans in file. Staff told us they did not read the care plans. Staff said, "Care plans are for the clients, we have bedside forms" and "We know people's history, families tell us." This meant staff did not use information in care plans to provide support for people and their needs may not be fully met as a result.

One person who had started using the service four days earlier told us they were anxious about being in a new environment, but there was nothing documented within their care plan to indicate if staff knew of this, or to inform staff how to alleviate the anxiety. There was a plan for restricted mobility which did not detail which type of manual handling aids should be used. The person had been assessed as high risk of developing pressure sores but there was no plan in place informing staff how to prevent this from happening.

We observed one person being hoisted into a chair by two members of staff. The person was very anxious about this. Although staff gave some instruction to the person they did not talk it through while the person was being hoisted and did not offer reassurance. Another person said, "I do not feel safe and feel very vulnerable in the hoist. I hate dangling while they sort it out". One relative told us there had been problems when staff used a hoist to move their relative; this was corrected when it was realised that the wrong sized

sling was being used.

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

During the inspection, we saw staff did not always respond to people quickly because some people were calling out and asking for help but had to wait for help to arrive. On one occasion, the inspector had to press the buzzer because the person did not know they could use it to call for staff. During the medicines round on the second day, an agency nurse was checking to see if anyone was due medicines. One person's bedroom door was closed and we could hear them calling. The agency nurse needed prompting to check if the person needed assistance. This meant people did not always get the support they needed in a timely way.

Care plans for people using the residential unit were more person centred. One plan contained details of how staff should care for a person with a catheter. The plan detailed which areas the person was managing independently and when they would require support from staff. The plan detailed when the catheter was due to be changed and there were notes in place from when the district nurse had visited to do this.

The home provided activities seven days a week arranged by two dedicated activity co-ordinators. Activities varied from quizzes, arts and crafts, bingo, pampering sessions, exercises, visits from outside entertainers and trips to local shops and pub lunches. There were some one to one sessions for those people who stayed in their rooms. A list of activities offered to people was on display in the entrance hall. Some of these activities were not suitable for people who were unable to mobilise because they were group activities in a communal area. One person's activity document recorded they had visited the shopping trolley as an activity, even though they had not bought anything, and recorded having their hair brushed as another activity. This meant not all activities were meaningful and added to the person's quality of life. Other individual activities the person had received included having their nails done and quizzes. The homes own analysis of the annual questionnaire showed while 53% of people said they had access to entertainment and trips out, 29% of people said they did not have access to entertainment and another 18% said they did not go out. This meant much of the entertainment provided did not meet people's equality and diversity needs because some people were unable to participate.

A copy of the complaints procedure was on display in several locations throughout the home. We saw the complaints file which showed one complaint was in the process of being dealt with. Other complaints had been closed. One relative told us they had not been informed of the outcome of a verbal complaint; however we did not see this recorded in the complaints file. This meant not all complaints were recorded. We saw a letter complaining one person's TV had been angled so the person could not see it. While walking around the home, we saw two people whose TV's were angled away from them so they could not see the screens. This meant staff had not learned from this complaint and were not making sure people could see their TV screens. Staff told us if they received any complaints they would report them to the nurse on duty or the senior if the nurse wasn't available.

Where the registered manager had made safeguarding alerts, some of these had triggered the complaints process. The complaints were investigated and recommendations made to prevent recurrence. As a result, some staff had attended further training including manual handling, safeguarding, dignity in care and use of the English language. The records showed staff involved had been closely supervised for three to six months afterwards. This meant the complaints had been used to improve the service. A dignity and respect audit identified that people couldn't recognise care staff, so a staff photo book was put in place to address this. This meant the service responded to people's identified needs.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. The results of the satisfaction survey also showed most people felt they were involved in planning their care and thought staff were polite and friendly. Staff told us relatives were invited for meetings every six month to review the care provided. However, most of the people we spoke with were not aware of their care plan and were not involved, as far as they knew, in any reviews. Relatives said, "We're fully involved in all aspects of the care and have had input into the care plan". They told us their relative was consulted in the decision making process. This meant people or their relatives had contributed to the assessment and planning of their care. Although care plans appeared to have been internally reviewed regularly, there were gaps in the reviews. One person's care plan for manual handling was last reviewed in September 2015; there were no further updates after this.

People were supported to maintain contact with friends and family. We saw friends and relatives were welcome to visit whenever they wished, although the home tried to operate a protected mealtime policy. This was to ensure people were supported to eat in a relaxed and unhurried environment. People were able to have their own phones in their rooms if they wished, and one person kept in touch with their family using emails and internet.

Requires Improvement

Is the service well-led?

Our findings

Audits had failed to identify the concerns we found which amounted to breaches of the regulations, such as the unsafe practice around medicines. Medicines audits had not picked up the lack of competency assessments for staff to administer medicines. Although three members of staff had noticed a repeated error on the MAR charts, this had not been reported as an error and audits had not picked this up. Two staff had not signed the acknowledgement that they had read and understood the policy and procedures they were expected to follow. Although the home's own audit had identified some areas where they were not following their policy, the audit had not identified all of the actions that were necessary to become compliant with their own requirements.

Audits of records had not identified the lack of information for staff around medicines. This meant medicines had not been applied or used as prescribed. Audits had not identified the difficulties staff faced by having different codes in use for MAR's charts on each of the floors, which meant staff became confused about which code they should use. No actions had been taken to improve the way medicines were stored. Medicines had, at times, been stored higher than their recommend temperatures which could impact on the effectiveness of the medicine.

Staff had not used the correct settings for air mattresses, which meant people were at increased risk of developing pressure ulcers. Wound care plans had gaps in the recording which meant it was not possible to see what treatment had been provided. Several records, such as the nursing dependency tool, contained incorrect information which could put people at risk. Emergency information was out of date, which meant people would not receive the support they needed in the event of an emergency. This meant the quality assurance and clinical governance was not effective and did not drive improvement.

Audit of the MCA/DoLS file had not identified the lack of consent or that staff were not aware of legal requirements. One person's care audit and action plan completed in September and October 2015 had gaps so it was not possible for the provider to be sure that risk assessments had been audited as complete. This audit had also left other sections blank, such as the person's health and that choices for gender specific care had been available.

Audits of care plans had not identified the limited information or lack of care plans to give staff the information they needed. Accurate records had not been kept which meant there was a risk people would not receive the care and treatment they needed. The use of inappropriate language, such as the use of the word 'nappy' had not been challenged.

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

The home had been audited regularly by a senior member of the organisation between January and September 2015, however there were no further external audits after this date. The more recent audits had been completed by internally employed staff. For example, the infection control audit was completed in January 2016. This audit identified a trend where each audit had scored lower than the previous audit. This

was discussed with the registered manager, who was aware of the downward trend and said the way the audits were completed had changed and it was now harder to get a high score. They had an action plan in place to improve the score.

We saw the registered manager had dealt appropriately with staff disciplinary issues. They told us, "Staff work hard, they're really trying." Staff said the morale was "pretty good". One staff member said "We have some pretty good care staff here, but if staff don't love the job they shouldn't be here". Staff said the manager was "firm but fair". One staff member said "The manager is dedicated and that makes me inspired" and "We get involved in decisions on things we can implement to improve".

There was a staffing structure in the home which provided clear lines of accountability and responsibility. The registered manager was supported by a deputy manager. A clinical lead supervised the nursing staff. Senior health care assistants supervised healthcare assistants. Staff told us the registered manager was approachable and they would be listened to if they raised any issues. Staff said, "The door is always open" and "We can see [name] at any time." Most staff said they felt well supported and able to raise any concerns or queries with their line manager. They said "I have a good open relationship with my manager, they always listen to me" and "I do feel supported by my manager".

There were meetings for people who lived at the home and their relatives, which gave everyone the opportunity of providing feedback to the home. Residents meetings were held every three months and the last relatives meeting was held in October 2015. One relative said, ""I have found the manager to be friendly and helpful, she is very approachable and able".

The registered manager was a registered nurse; they kept their skills and knowledge up to date by on-going training and reading. The registered manager had a clear vision for the home. Their vision and values were communicated to staff through staff meetings and formal one to one supervisions. Staff told us, "The values are on display" and "It's to be the best." In the staff survey however, staff had not rated the home as excellent. Staff rated training, manager communications and level of supervision as good to very good.

All accidents and incidents which occurred in the home were recorded and analysed. We saw accident records which showed there had been three accidents in 2016. The registered manager was able to demonstrate people had been referred to the falls team and additional staff had been provided as a result of analysing accident information. This meant the registered manager responded to the accident information and made changes to reduce the likelihood of the accidents recurring.

A variety of meetings were held. These included staff meetings for senior staff, carers and domestic staff. The meetings were used to inform staff of events which were relevant for their roles. We saw the home held 'flash meetings', where staff on duty were called to an immediate meeting to be informed of a current issue. We observed one of these meetings taking place, where four care assistants were informed the pressures of the air mattresses were not right. The staff were asked to check the air mattresses had the correct pressures in them. Staff were also told they were doing a good job of keeping food and fluid charts updated. This meant the registered manager had a system in place for raising issues urgently if necessary, which also meant people didn't have to wait for things to be addressed.

The home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

The registered manager sought people's feedback via a questionnaire. The results of the last residents' questionnaire from July 2015 were posted on the notice board for everyone to see. The results showed that

most people didn't know who their keyworker was. One relative told us, "A photograph of a keyworker has been on the door for over a year, but we've never seen this member of staff." Another relative told us they had never seen a keyworker in 12 months of regular visiting. No action had been taken to address this. Several groups of people took part in satisfaction surveys which included relatives, internal staff and professional visitors. The results of the professionals' questionnaire showed a high level of satisfaction. One person who had stayed at the home for respite care rated the service 12/12 and said they would recommend it.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment did not meet people's needs and did not reflect their preferences. Regulation 9 (1) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not provided with the consent of the relevant person. Regulation 11 (1)

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 People were not protected against the unsafe use of medicines. Regulation 12 (2) (g) Staff did not have the qualifications, competence, skills and experience to do so safely. Regulation 12 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate, complete and contemporaneous record in respect of each service user were not kept. Regulation 17 (2) (c)

	Systems to assess, monitor and improve the service were ineffective. Regulation 17 (2) (a) Systems and processes did not mitigate the risks relating to the health, safety and welfare of the service users. Regulation 17 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The home did not have sufficient numbers of suitably qualified, competent, skilled and experienced staff. Regulation 18 (1)