Care Quality Commission

Bupa Care Homes (BNH) Limited

Anville Court Nursing Home

Inspection report

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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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 21 and 22 July 2015 and was unannounced. At the last inspection in July 2014, the provider was meeting all of the requirements of the regulations that we looked at.

Anville Court Nursing Home provides accommodation with nursing and personal care for up to 50 older people, including people with dementia and people with disabilities. At the time of our inspection there were 36 people living in the home.

At the time of our inspection the home had an interim manager in place, but did not have a registered manager. The provider informed us after the inspection that a registered manager had been appointed. 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.

Summary of findings

People were not always protected from harm as staff did not all know how to report any suspected abuse or who is responsible for investigating any concerns. People did not always receive safe care as their needs were not always correctly identified or acted upon.

People's medicines were not always managed safely. We saw that medicines were not always recorded correctly and instructions were not followed correctly by nursing staff.

Staff were not appropriately deployed to meet people's needs. People and staff told us there were not enough staff, and we saw that people's care was delayed because of the deployment and management of care staff.

The provider had not followed the correct processes for gaining people's consent for care or for gaining authorisation to restrict people's freedom. We saw people were being kept in bed when their preference was to be outside in the garden when possible. That the provider did not always follow the legal requirements to assess people's capacity to make decisions about their care and people may have been deprived of their liberty unlawfully.

Staff had not received all of the training they needed and did not have the additional management support they required in their work. Staff members told us that supervision was used 'as a weapon' and there rarely had one to one support or appraisals in order to address training and develop needs.

People were not all provided with appropriate food and drink to meet their health needs. We saw people did not always receive the fluids they needed. People were mostly happy with the food they were provided with, but some people did not receive choices of food related to their personal preferences despite this being detailed in their care records. People's health needs were met and they were supported to access a range of health services outside of the home.

People told us some staff were caring and treated them kindly, but some were less caring and focused on tasks. People were not always asked about their preferences for their care or provided with different options for care. Staff respected people's privacy and dignity when providing them with personal care.

Care was not responsive to people's individual needs. People told us they didn't take part in appropriate activities and their preferences were not taken into account about when they got out of bed or how they spent their days. People's care plans were focused on clinical need and did not provide personalised information in order to guide staff in people's personal likes and dislikes.

The provider did not adequately respond to people's complaints. We saw that complaints had not all been responded to or investigated in line with the provider's own policy and people told us they had given up complaining as their concerns had not been addressed.

The provider did not make sure the home had appropriate management and leadership. There was not a registered manager in place and there was a lack of good clinical leadership. The provider did not have a quality assurance and audit system in place to identify any problems within the home, and had not been able to identify the issues that we found in this inspection.

During the inspection we found 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 the report.

The overall rating for the service is 'Inadequate' and the service is therefor in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If no improvement is made within this timeframe so that there will still be a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection

Summary of findings

will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer as inadequate in any of the five key questions it will no longer be in special measures.

Summary of findings

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 were at risk of harm as staff members were not all aware of how to report potential abuse correctly and reports of bruising were not investigated or reported appropriately.

People did not always receive care when they wanted as staff were not appropriately deployed to meet their needs. People's medicines were not managed safely and some were not stored correctly.

Is the service effective?

Requires improvement

The service was not effective.

People's consent was not always obtained appropriately which meant people were being restricted in their freedom without the correct authorisation.

People were supported by staff who did not receive adequate support for their work

People were not always provided with adequate food and drink to meet their health which meant specific needs for fluid intake were not met

People's health needs were met and they were supported to access other health services.

Is the service caring?

Inadequate

The service was not always caring.

People did not always receive care that responded to their preferences and staff were focused on tasks.

People told us that some staff were abrupt and were not kind or caring in their approach while others were caring.

People's privacy and dignity was respected by staff.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not personalised to people's individual needs.

People told us there were not appropriate activities and they did not always receive the care they wanted.

People's complaints were not always responded to or investigated in line with the provider's complaints policy.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

People's care was not effectively monitored by the provider to make sure they received the level of care they required.

There was not a registered manager in place. There was inadequate clinical leadership to monitor the standards of care provided for people.

Anville Court Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 21 and 22 July 2015 and was unannounced. The inspection was done by two inspectors, a pharmacist inspector, a specialist advisor who was a nurse with specialism in wound and pressure care management, 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 service. We completed the Short Observational Framework for Inspection (SOFI) which allowed us to observe the care provided for people who were unable to speak with us.

We looked at the information that we held about the service. This included the notifications that the provider had sent to us, which included details of incidents that had taken place that the provider is required to send to us by law. We also looked at three reports from the Clinical Commissioning Group (CCG) from their inspections into people's care. We spoke with the local authority and CCG about the care provided.

During the inspection we spoke with fourteen people living in the home and five relatives, four nurses, five care staff, the interim home manager and the regional manager from the provider. We looked at different records about the care provided and management of the service. We looked at seven people's care records, five staff files, the complaints file and the medicines records for ten people.

Inadequate

Is the service safe?

Our findings

People were not always protected from abuse or improper treatment as we saw that the provider did not have adequate systems to monitor the care provided or identify patterns of incidents that occurred. However, people did tell us that they felt safe within the home. One person told us, "I like it here because it's very clean and people are always around me." We spoke with a relative who was concerned about the treatment of their relative. They told us, "[Person's name's] pyjamas are ripped with no buttons left. [Person's name] has bruises on their arm and don't know where they're from." We looked in the care file for this person and saw that staff had recorded bruising, red marks and skin tears on this person's arms on three separate occasions, but these had not been investigated or reported as safeguarding concerns as is required. We discussed these incidents with the manager who was not aware of these incidents and could not provide us with any additional information, but agreed with the severity of the concerns raised. The manager raised a safeguarding alert with the local authority about this person.

We looked at the care records for another person who was identified as having behaviours that challenged the service. The records did not provide information for staff to follow to manage this person's behaviours safely and effectively with no clear instructions on how to deal with physical and verbal aggression. We saw in this person's records that staff had completed body map records on two separate days that detailed bruising to the person's arms. We discussed these with the manager who was not aware of these incidents. The manager confirmed that these incidents had not been investigated or reported to the local authority. The manager made the appropriate report to the local authority for this person. We saw that some safeguarding alerts had been raised where concerns had been identified, but we saw that safeguarding concerns were not always identified and had not been reported and the correct procedures had not always been followed.

Staff members knew about the different types of abuse, but did not all know about the correct procedures to report any concerns. There was guidance in the safeguarding policy but not all staff knew this. Care staff told us they would report incidents to the nurse or manager, but did not know how to report concerns to external organisations including the local authority and CQC.

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

We observed the care provided and looked in the care records for two people we observed and saw that they did not receive adequate care and the records did not provide appropriate risk assessments. We saw one person being given their lunch in their room on both days of our inspection. On the second day we saw they were given their meal while they were asleep in their chair, and the care worker woke them up and startled them when they brought the food in. The person then fell back to sleep and did not eat any of their meal before it was taken away. We saw this person was not provided with the support to eat that they required which had been outlined in their care plan and risk assessment, which stated they required support to eat and drink.

We looked in detail at 14 medicine administration records and found that people were usually receiving their oral medicines at the frequency prescribed by their doctor. We however had concerns that a person who had been prescribed an antibiotic which needed to be administered on an empty stomach was receiving it with or just after their meals, which meant the antibiotic would not work properly. We spoke with the nurse who was not aware of this requirement. We also found that two people were not receiving the correct dose of their inhaled medicines and this posed a risk that these people's breathing difficulties were not being effectively managed.

We looked at records for people who were having analgesic skin patches applied to their bodies. We found the provider was on the whole making a record of where the patches were being applied. We looked at four of these records and found that the patches were not being applied in accordance with the manufacturer's guidelines. The provider was not able to demonstrate that these patches were being applied safely which could result in the risk that people's pain would not be well controlled.

We found that the refrigerator temperatures were not being correctly measured. We asked a member of staff to show us how the nursing staff were measuring the maximum and minimum temperatures. We found the measurements being recorded were not the maximum and minimum temperatures of the refrigerator. We were particularly concerned because the minimum reading for one of the refrigerators was one degree Celsius. We found that this refrigerator was storing a temperature sensitive medicine

called insulin and the poor storage would have meant that there was risk that people's diabetes would not be effectively controlled. We could not be sure if the medicine had been affected by the fridge temperature which could place the person at risk of harm if the medicine was no longer effective.

Information available to the staff for the administration of 'when required' medicines was not detailed enough to ensure that the medicines were given in a timely and consistent way by the nursing staff. We spoke to a member of the nursing team who told us that further information would help them to better understand and decide when it would be most appropriate to administer these medicines.

The provider had plans to start administering medicines to a person using the service by disguising them in their food or drink. We spoke with the nursing staff and found that other options to help and encourage this person to take their medicines had not been explored. The nursing staff were also not aware of the safeguards required to ensure this process was carried out legally and safely. We saw that the provider had obtained authorisation for this procedure but had not explore other options for this person that would be less restrictive. The medicines this person received could not all be crushed and put into food safely, and the provider had not sought advice from the pharmacy about different medicines to use to do this safely.

We found that where people needed to have their medicines administered directly into their stomach through a tube the necessary safeguards not were in place to administer these medicines safely. There were no written protocols in place to inform staff on how to prepare and administer these medicines and therefore there was serious risk that people's health and welfare could be affected. We spoke with nursing staff who were not all clear about the procedures to follow and told us incorrect ways they gave people these medicines.

We found people were well supported to administer their own medicines. We spoke with one person who had expressed a wish to administer their own medicines. This person explained what the provider had done to ensure that they were well supported to administer their medicines and store them safely.

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

People told us they felt the home did not have enough staff to provide them with the care they needed. One person told us, "Sometimes I don't feel secure as staff need to use special slings adapted for me and need two staff to handle me with. Staffing levels can put people at risk, which worries me." Another person told us, "Staff, they are golden to me, they just need more staff. I feel sorry for the staff, they don't have time for a cup of tea. They work long hours and get stressed, which is not good for their family or the service here." One relative told us, "At weekend's there's never enough staff."

We saw that staff were rushed in their work in the morning to try and provide breakfast for people and were not able to spend time with people and provide them with the care they wanted. We discussed the staffing levels with the manager who told us the staff numbers were decided by the provider. We saw that staff were not deployed effectively to make sure that people received care at the times they wanted it, and saw that some people got out of bed early but then had to wait for their care as staff were not available to support them.

We saw one person who had a drink near them but could not reach it. We spoke with a member of staff about how this person would get a drink if they wanted one. They told us, "It depends on how many staff we have got as to how often they get a drink." We saw that people were not always given drinks or support when they requested it, and that staff were not always able to provide people with the support they required. We spoke with one person about the support they required to eat. They told us, "I am aware of how busy the staff are and don't want to bother them unless it was an emergency."

On the first day of our inspection we saw that most people were in bed for the whole morning, and that people were still receiving their breakfast at 10.30am. People told us this was not their choice or preference. We spoke with the manager who told us this was how staff worked and they wanted to change this culture. We saw that some people had got up early in the morning but still had to wait for the breakfast as the staff were unable to support them until later in the morning because they had other people they needed to attend to first. People told us they wanted to be up and liked to be in the lounge or dining room in the morning rather than spending so much time in their rooms.

We saw that care staff were consistently busy attending to the people in their rooms, and struggled to provide people

Inadequate

Is the service safe?

with the support they needed to eat. We observed a care worker supporting to someone to eat quickly, where they were holding the next spoonful to their mouth before they had finished the previous mouthful, and rushed them to eat so they could continue their rounds and support the next person. We saw this and the manager told us they had observed this happening as well.

Staff members told us they felt there were not enough staff and they were rushed and did not have the time they needed to care for people. One member of staff told us, "Sometimes we struggle with staffing." Another care worked told us, "The staff levels are unsafe." This staff member told us they were concerned about the number of staff to support people and that many care workers felt overworked and could not provide people with safe personalised care. We saw that care staff were not effectively deployed and they struggled with their work as they had to provide support in people's rooms and could not effectively care for people at the time they wanted it.

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

Requires improvement

Is the service effective?

Our findings

People's consent was not always obtained appropriately for their care and the provider did not meet all of the legal requirements when depriving people of their liberty. We saw that many people had rails on their beds to prevent falls, but these had not been adequately assessed to identify if these were the least restrictive option for these people. We saw that people had not all been involved in these decisions. We saw examples of assessments for bed rails in people's care files. We saw in one person's care file the initial assessment was done in June 2014 and was regularly updated each month until November 2014, and then was not checked again until May 2015. This person had an incident in May 2015 where they were injured by the bed rails. The care plan was not updated following the assessment and there had not been a full assessment to decide if continued use of bed rails was appropriate for this person.

We looked in one person's care file and saw that the process for making decisions in their best interests and assessing their capacity to make decisions was not followed correctly. The assessment of their mental state and cognition stated that they liked to interact and engage in conversation. The mental capacity assessment stated this person had an impairment of the mind, was unable to make decisions, did not understand information, was unable to communicate and lacked capacity to make decisions for themselves. The best interest decision form for this person stated that it related to all aspects of the person's care. The rest of the form was blank and contained no information about the person's preferences, no details of consultation with the person's family or other professionals. This process does not follow the legal requirements for assessing people's capacity to make decisions about their care and support.

We saw in another person's care file contained a 'consent to care' form that had been signed by a family member of the person. The family member did not have lasting power of attorney in order to make this decision, and the person had the capacity to make this decision for themselves.

People were supported by staff who had received training in order to do their work, but did not always have enough knowledge to be effective. We spoke with three care workers and two nurses about their understanding of people's capacity, and none of these members of staff could demonstrate they understood the importance of providing people with choices and understanding their capacity to make decisions or understand information presented to them. One member of staff told us they had not received any training on the Mental Capacity Act or Deprivation of Liberty Safeguards, which are important legal requirements when providing care to people. Another member of staff also told us they had not received this training.

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

We saw that there were people who were identified as requiring their fluid intake monitored. We looked at the records for these people and saw that this was being recorded but these people did not receive the amount of fluids they required. Staff members told us they did not always have the time to support people to have the level of fluids they required. We saw one person who had a medical condition that required monitoring and management of their food and fluid intake and at risk of developing pressure sores required 1600ml of fluid per day. We saw in their daily records that they received an average of around 700ml per day and the person we saw the person appeared dehydrated. We raised this with the manager who told us they would investigate and make sure the person received appropriate drinks. This meant the person was at risk of dehydration and increased risk of pressure sores as fluid intake relates to skin integrity.

We saw a complaint that stated items, including drinks, were left out of reach of their relative. This stated it had been actioned and a staff member had received supervision. However, during the inspection we saw several incidences where drinks were placed out of people's reach and they were not able to have them and staff were not available to help people to have their drinks. We saw that people did not have drinks available to them, and people told us that they were not always able to have drinks when they wanted them.

We saw that people were offered a choice of food based on the menu for the day, and an alternative menu was available if people did not like the main choices. People gave us different views on the quality of the food. Most people liked the food provided but some people were not happy with the food they received. One person told us, "The food is edible and there are enough portions."

Requires improvement

Is the service effective?

Another person told us, “The food’s really good.” One person told us, “The food is good and I am very picky.” We saw that food was well presented and had been freshly prepared.

We spoke with one relative who felt that their relative’s cultural needs were not being met. They told us, “[Person’s name] can’t communicate due to the language barrier and this home needs to offer food according to [Person’s name’s] dietary needs.” We saw that this person's care plan stated the type of food that was their preference. We asked staff about this and they told us they were not aware of this person’s preference. The provider had shown food diaries that indicated that different cultural food options were available. The person’s relative told us that they did not receive the food that they liked or was from their cultural background.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that all care and nursing staff had received recent training in pressure care and wound management. We discussed this with staff who told us they were more confident in recognising any problems with people’s skin and knew to report these to the nurses quickly and what care they needed to provide to prevent these from developing into pressure sores. We saw that staff were using the correct pressure relieving equipment and they had the correct settings for people as specified in their care plans.

People told us that they thought staff members were skilled at their work. One person told us, “They seem to know what they are doing. I think they do get training.” However, one relative also told us, “They don’t seem to be trained on mental health, but staff are very friendly.” Staff members told us they did not always receive the support they required, and did not receive regular supervision or management support to help them with their work. We asked a member of staff about the support they received from their manager through one to one meetings. They told us, “I can’t remember the last time I had one. It was either last year or the year before.” Another member of staff told us they had only had supervision once since they started. We discussed this with the manager who told us that supervision was not done regularly and staff viewed it “As a weapon” that was only used if they had done something wrong. The manager told us they were creating a new system for supervision and that all staff would receive regular supervision and annual appraisal to help them provide quality care and respond to people’s needs.

People and their relatives told us that they were able to see other health services when they needed hem. One person told us they had regular visits from their doctor, chiropodist and optician. People’s health was monitored by the nursing and care staff, with referrals made to other services when they need them. We saw that there had been problems with people developing pressure sores, and that the local specialist services had not been called until the sores had developed. We saw that the provider had worked to improve this and care workers were reporting problems with people’s skin quickly and this was being managed more effectively. We saw that people were supported to see their doctor, attend hospital appointments and there were regular visits from other health professionals. We saw details of visits by the optician and podiatrist to help maintain people’s health.

Inadequate

Is the service caring?

Our findings

We spoke with people about the home and how they were treated by staff. Some people told us they found the staff to be caring, but some people felt staff were too rushed and focused on tasks to care for them properly. One relative told us, "Some staff are very friendly and supportive but some staff are rude, they don't have eye-to-eye contact and don't have a friendly tone when communicating with the residents." Another person told us, "I noticed, when staff passed by [Person's name's] room they just say hi and walked away never gave time to talk to [Person's name]. One person told us, "The staff are marvellous, they are very kind." One relative told us, "I think the standard of care can be 100% if they have more staff." We observed care being provided and saw that some staff had good interactions with people and knew them well. We saw one person supported to eat their meal at lunchtime. The carer who supported them gave them time to eat, made sure they felt comfortable and made the meal a pleasurable experience for the person.

During our inspection we saw two incidents that demonstrated that not all staff were caring towards people. We saw one incident where a person was asking a nurse for support to go downstairs to the dining room. The nurse replied "You have a buzzer you can use" and told the person she did not know where the care worker was, rather than offering to support the person themselves. We spoke with another member of staff who told us they just followed the care plan and did not know what sort of questions to ask people about how they wanted to be cared for. We asked them about the types of questions they could ask someone. They told us, "Do they like the door open or closed when being fed. I hadn't thought to ask before."

We spoke with staff about how they cared for people. Some staff knew people well and had a good understanding of how people liked to receive their care. We observed one member of staff talking to one person at lunchtime, and they said, "I know you like ice cream and not the pudding," which showed they knew the person's preferences and responded to them. The person had the pudding they preferred and appeared happy with their meal. One member of staff told us that they understood people may change their minds daily depending on how they were feeling, "So I always ask and explain things."

People told us they were not always supported to be independent and did not always have the opportunity to interact with other people. One person told us, "I spend all morning in my room… Some people with poor mobility are always in their room. It would be nice if staff could take them to the lounge to break the isolation." One relative told us, "My relative is always in their room and they don't do any meaningful activities." Some staff members told us how they offered people choices wherever possible and supported people to be independent, while other staff did not understand about choice and personalising care for people. One member of staff told us, "We encourage people. There was one person who did need a full hoist but can now take a few steps for themselves."

We saw that people were spending most of their time in their rooms, with many people staying in bed for much of the day. We spoke with people and asked them if this was their preference. One person told us, "I like getting out of bed in the morning – it hasn't happened for ages and I feel so much better for it [being out of bed]. I hate being in bed until dinner time."

We saw this person was in bed until the afternoon on the first day of our inspection, and they told us they often had to spend most of the day in bed, which was not their preference. We asked the manager about people being in bed, and they confirmed that people's care and preferences were under review.

We spoke with one person who told us that they had not been out of bed for two weeks and wanted to go out into the garden. They told us that they enjoyed sitting outside and would like to go into the garden twice a week, but had not been supported to get out of bed and was unhappy about this.

We saw that people were well dressed in clothes of their choice and reflected the season. One relative told us, "My relative is always well dressed but it would be nice if they gave them a bath twice a week." Staff members did respect people's privacy and dignity. We saw that they used a sign on the door to people's rooms when providing personal care to let people know not to disturb them. We observed that staff used people's preferred names when talking to them. We spoke with one member of staff about how they made sure they respected people's privacy and dignity. They told us, "I make sure the door is closed, I put towels around people." We saw one member of staff knock on the door of a person's room and had brought them a sandwich.

Inadequate

Is the service caring?

The carer explained to the person that they would leave the sandwich for them. The conversation indicated that the carer knew the preferences of the person and the carer was kind and caring towards the person.

Inadequate

Is the service responsive?

Our findings

People did not receive care that was tailored to their needs as we saw that care staff were focused on tasks and working through these rather than providing care that responded to each individual person. We saw that people were given breakfast in their rooms at a set time, based on when the care staff were able to do this, rather than when people got up and wanted to have their breakfast. One member of staff told us that it was easier for them to give people breakfast in their rooms than to have people getting up first. We discussed this with the manager who agreed the care was task-oriented and not personalised to the needs of people living in the home.

People told us that there was not enough to do and there were not appropriate activities to stimulate them. One relative told us, "The visitors have tried to get everyone into communal areas on a weekend as there's nothing." They also told us, "It's sometimes 10.30 before they're washed and out of bed. [Person's name] needs to be moved regularly and can sometimes be left in their chair until 3pm. They can't walk or lift their hands but he doesn't get any exercises." On the day of the inspection we saw this person was being dressed at 1pm and was then back in bed. We asked the manager about this and they did not know why the person was back in bed. Their relative told us, "I don't know why they're back in bed and not in the chair."

Throughout the inspection we saw that people mainly remained in their rooms with their televisions on. We saw one person was asleep and the television had been left on loudly while the person was sleeping. We asked staff if this was their request, and the member of staff did not know and we could not be sure if this was the person's preference.

We discussed the activities with the manager, who told us that there was a limited programme of activities for people. We asked what activities were available for people dementia to support their memory. We were informed there were no specific reminiscence activities at present but there were plans to develop memory boxes and provide more activities for people. We saw a care worker run an exercise activity for people seated in the lounge on the second day of our inspection. We spoke with the manager who told us there was a lack of meaningful activities for people in the home and they wanted to improve this. One member of staff told us that not many activities happen and staff are always too busy to engage with people.

We looked in people's care records and saw that these were based on medical need and people's health conditions and did not reflect their personal preferences and information about their lives. We spoke with nursing staff who did not all know about people's preferences and care needs. People's care plans were not personalised and did not provide care staff with adequate information to provide people with person-centred care or provide appropriate details of how to support people to make decisions about their care. We saw the pre-admission assessments for people were all tick box questionnaires and did not provide personalised information about people. We discussed this with the manager who believed these were sometimes done by telephone, and that nursing staff did not have a good understanding of people's needs before they moved into the home.

We saw in one person's care file that it stated the person needed to be hoisted at all times and was unable to walk. During the inspection we saw this person was able to do some tasks for themselves and was able to walk with a frame and support. The assessment for this person was a series of tick boxes about their medical history and did not provide details about their individual needs or preferences for their care. The assessment contained no personal information or details on how to care for this person or how to engage them within their care other than the tasks specified in the care plan. The 'Who am I' section of this person's care plan was not completed at all, so there was no personal information for care staff to use to support this person effectively. We looked in the daily records for this person and saw that the instructions within the care plan were not always followed correctly which placed this person at increased risk of dehydration and of developing pressure sores.

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

People told us they would talk to staff if they wanted to complain but were not confident that these would be dealt with. One relative told us, "You don't get anywhere making

Inadequate

Is the service responsive?

a complaint. I've made a number over the last 12 months." The provider had a complaints policy in place, but this policy had not been followed correctly and people's complaints had not been dealt with appropriately.

We looked at the complaints file and identified a number of complaints that had not been investigated or responded to and we looked in detail at eight complaints. The manager told us that they had found the complaints file behind the filing cabinet and the previous manager had not investigated or responded to these complaints. We saw that the file was not in order and that people's complaints had not been responded to or treated with concern by the manager. We saw one recent complaint from a relative who told us that they had found their relative was soiled with faeces. They complained to a member of staff who told them that they would return to provide personal care, but then did not. The complaint had not been investigated and there were no actions from this. We showed this to the manager who told us they would investigate the complaint and take any necessary actions.

We saw complaints from two relatives about the treatment their relatives had received. Both of these complaints stated that their relatives' clothes had been ripped and the standards of care were poor. We saw that one of these people had made several complaints about the same issue and they had not been addressed appropriately.

We discussed the complaints process with the manager who told us they had reviewed the system and had started a new process and were investigating the outstanding complaints. They acknowledged that people's complaints had not been addressed appropriately and that changes had not been made following people's complaints previously.

This was a breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We saw that safeguarding concerns were not effectively identified and that the appropriate referrals had not been made to the local authority and CQC, as the provider is required to do by law. We saw examples where concerns had not been raised by staff and there were not adequate audit and review processes to identify such concerns, which meant people continued to be at risk of harm.

We identified there were patterns in people's care records that suggested that people may not have received safe care. We saw details of reports of repeated bruising and marks on a person's skin. These had been noted in the daily records for this person, but had not been identified by nursing staff as a potential issue to investigate. We discussed this with the manager who told us the process was that nurses would file these records each week, and they were not audited or assessed. As a result, potential harm had not been identified. We asked the manager to raise a safeguarding alert for this person because of the concerns we identified within the care records.

We saw that the provider did not have adequate management and leadership within the home to provide people with high quality care. We spoke with people about the staffing levels and they told us they were concerned about the number of staff. One person told us, "I brought it up at the meeting. I was told that the manager asked but was told Bupa said they were adequately staffed." Relatives told us they were not happy with the management of the home and they did not have confidence that the provider would make the changes they felt were necessary. One relative told us, "We haven't got a new manager. Everyone is temporary."

We spoke with a member of staff about the culture of the home and how they are involved in any changes to the service. They told is, "I don't feel encouraged. I don't think what we say will change." Staff members did not feel involved in the development of the service and that their voices were not heard when decisions were being made about any changes. Another member of staff told us, "It's been a lot to take in and some of the staff are very dissatisfied. Morale's down at present."

There was an acting manager in place, who told us they were going to register as the manager with CQC. The manager was visible and interacted well with people and people told us they had made positive changes since they started. One relative told us, "We haven't got a new manager. Everyone is temporary." We asked them about this and they told us that there had been several different managers since their relative had been in the home, and they did not have confidence in the provider in keeping a manager in post. Another relative told us, "The current changes of management system damages the whole service. The first manager left quick, the second was very good and the third also left within three months and they didn't introduce themselves to the relatives. The current manager is approachable but I am worried they are also on a temporary basis."

The provider did not complete adequate audits and quality assurance processes to make sure that people received the care that they required or that people were happy with their care. We discussed the quality assurance and audit process with the manager. They told us that there had been little auditing of the service until June 2015 by the previous manager, and there were significant gaps in the recording and monitoring of the quality of care. During our inspection we identified a number of shortcomings in the standards of care that had not been identified by the manager or the provider since the last inspection and found that people had not always been provided with quality care.

The provider did not provide appropriate clinical leadership to make sure that people receive safe and effective care in line with national standards for care. The procedure for auditing and managing medicines was not effective and had not identified all of the issues that we identified through our inspection. We identified concerns about management of medicines including people receiving medicines through tubes, and had previously received notifications about errors made when giving people these medicines. We saw that this had not been addressed and nursing staff were not able to provide people with their medicines correctly, when this had previously been identified as a problem. Nursing staff were responsible for managing people's care and making sure that received the correct care for their needs. This was not assessed properly and we identified instances where people's care was not appropriate and people were receiving medicines in a way that contradicted the manufacturer's guidelines. The decision to request authorisation to give covert medicines to one person was not taken in the person's best interests and had now followed appropriate guidance to use alternative methods,

Inadequate

Is the service well-led?

such as liquid medicines and different times of day. We spoke with the clinical lead about this process and they told us they had not spoken to the pharmacist about changing the medicines for this person and had not identified that the medicines could not be crushed and given in food.

The provider had not completed adequate audits of the records held for people and staff. We identified that there were gaps in the records kept for people, with the reviews not taking into account changes in people's needs and preferences.

On the first day of our inspection we saw that two people's records were left on a shelf in a corridor near to their room. These records contained confidential personal information, and as such are required to be kept securely to maintain people's confidentiality. We discussed this with the manager, who asked a member of staff to move the files. On the second day of the inspection, we saw the files were still on the shelf in the corridor, where anyone within the home would be able to access them.

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

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People were not provided with care that met their needs, and the provider had not completed appropriate assessments of these needs.**

The enforcement action we took:
We are considering the enforcement action we will take in response to this breach and will report on this when the action is complete

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not always appropriately assess people's capacity to make decisions about their care and did not always work within the guidelines of the Mental Capacity Act**

The enforcement action we took:
We are considering the enforcement action we will take in response to this breach and will report on this when the action is complete

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People's medicines were not always managed safely. People were not always provided with safe care that met their identified needs.**

The enforcement action we took:
We are considering the enforcement action we will take in response to this breach and will report on this when the action is complete

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People were not always protected from abuse as the provider did not always identify potential abuse and these were not reported to the appropriate authorities**

The enforcement action we took:
We are considering the enforcement action we will take in response to this breach and will report on this when the action is complete

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People did not all receive adequate food and drink to maintain their health**

The enforcement action we took:
We are considering the enforcement action we will take in response to this breach and will report on this when the action is complete

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider did not respond to people's complaints and had not investigated complaints appropriately.**

The enforcement action we took:
We are considering the enforcement action we will take in response to this breach and will report on this when the action is complete

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not complete adequate audits and monitoring of care provided to ensure people receive adequate and appropriate care.**

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We are considering the enforcement action we will take in response to this breach and will report on this when the action is complete

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have staff adequately deployed to provide people with personalised care in a timely manner**

The enforcement action we took:
We are considering the enforcement action we will take in response to this breach and will report on this when the action is complete