Imalgo Limited

Lower Farm Care Home with Nursing

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

Summary of findings

Overall summary

Lower Farm Care Home with Nursing provides accommodation and care for a maximum of 46 people with varying healthcare and support needs. At the time of our inspection there were 39 people living in the home. People were accommodated over two floors.

At the time of the inspection there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

At the previous inspection in October 2015 we identified two breaches of the regulations. Improvements were needed to the quality assurance system and the care plans. The registered manager provided an action plan stating that they would take the action necessary to become compliant with the regulations by 29 February 2016. However, the system to monitor the quality of the care being provided and to drive improvement was still not effective and this impacted on all areas of the service. Work had commenced to improve the care plans so that staff had the information they required to meet people's needs.

Risks had not always been managed to keep people as safe as possible. The necessary fire procedures were not in place to keep people safe in the event of a fire.

We could not be confident that people received their medication as the prescriber had intended. Staff competence to administer medication had not been undertaken. Current legislation was not being followed regarding the storage and recording of administration of medication. Medication audits were not being completed regularly to identify any areas for improvement.

Staff had been employed without the necessary checks being completed. Staff had not all completed the necessary training or competency assessments. This meant that people could be cared for by staff who did not have the right skills, knowledge or competency.

Staff were not always aware of the procedure to follow if they thought someone had been harmed in any way. This meant that concerns may not be investigated appropriately and the appropriate action may not be taken. There was ineffective monitoring of care and other records to assess the risks to people and ensure that these were reduced as much as possible and to improve the quality of the care provided.

The Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The provider was not acting in accordance with the requirements of the MCA including the DoLS. The required assessments and decisions had not been completed to ensure that people continued to be able to make as many decisions as possible. Some people may have been unlawfully deprived of their liberty.

Adequate food and drink was provided. People had access to the relevant healthcare professionals.

There were not enough staff to ensure that people always received the care and support that they needed and in a timely manner.

The overall rating for this service is 'Inadequate' and the service is therefore 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 not enough improvement is made within this timeframe so that there is still 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 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 rated as inadequate for any of the five key questions it will no longer be in special measures.

We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is now considering the appropriate regulatory response.

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

There was not a safe system in place to ensure that the necessary recruitment checks were completed before staff commenced employment at the home.

Staffing levels were not sufficient to meet people needs in a timely manner.

Risks to people's safety in the event of a fire were not always adequately identified or adequate action taken to reduce the risk.

Medicines were not always managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not acting in accordance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards. This meant that people's rights were not always being promoted or protected.

Staff were not receiving the support or training that they required to meet people's needs.

People had sufficient food and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always upheld.

People were not always involved in the planning of their care.

Staff were seen to work in a kind and caring way for the majority of the time.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always provided with care that was person centred and met their needs.

Not all of people's care needs were properly planned for,

Complaints were not always recognised or responded to by the registered manager.

Is the service well-led?

Inadequate

The service was not well-led.

There was no effective quality assurance system in place to identify improvements needed and ensure that they were carried out.

The complaints system was not effective.

There were no processes in place to ensure that staff were competent to carry out their roles.

Lower Farm Care Home with Nursing

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 04 and 05 July 2016 and was unannounced. The inspection was carried out by two inspectors on the first day and an expert by experience and two inspectors on the second day. 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 the information we held about the service, including the provider information return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications the provider had sent us since our previous inspection. A notification is important information about particular events that occur at the service that the provider is required by law to tell us about. We contacted local authority commissioners and healthcare professionals that had contact with the service to obtain their views.

During our inspection we spoke with seven people who lived at Lower Farm Care Home with Nursing and four relatives of people. We also talked with the manager, four nurses, and three care assistants. We looked at the care records for three people. We also looked at records that related to health and safety and quality monitoring. We looked at medication administration records (MARs). We observed how the staff supported people in the communal areas. Observations are a way of helping us understand the experience of people living in the home.

Inadequate

Is the service safe?

Our findings

We inspected the home in March 2015 and October 2015 and rated the Safe domain as, 'Requires Improvement' on both occasions. In March 2015 we found there was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We stated that the staffing levels were not matched to the demand for the care and support of the highly dependent people living in the home. In October 2015 we found that there had been some improvements to the availability of nursing staff to carry out nursing tasks, however people were still waiting for long periods of time for assistance.

During this inspection we found that there was a further breach of the regulations regarding the staffing levels not matching the demand for care. The number of staff deployed was not sufficient to meet people's needs in a timely manner. The registered manager stated that she was not responsible for deciding the number of staff that were on each shift. She said that she was not aware of how the number of staff on each shift was determined. A representative of the provider stated that it was the responsibility of the registered manager to inform them how many staff were required on each shift to meet people's needs.

People told us that they had to wait long periods of time for their call bells to be answered. One person said, "When I use the call bell I tend to wait ten minutes or more, sometimes someone [staff member] will appear to say they will be back." Another person told us, "I used the call bell the other night and nobody came." A third person told us, "There aren't enough staff, they haven't got enough time for me and are rushing in and out with hardly any time to talk." One relative told us, "It took over 45 minutes yesterday to get a response to the call bell. In the end my [family member] went to find someone."

The staff also told us that the staffing levels were not sufficient to assist people with the help they required in a timely manner. One member of staff told us, "It's manic. I try to alternate who I help to get up first so that it's not always the same people that have to get up late. Today it was 1.15pm when I assisted the last person to get up." Another staff member told us, "There is a lack of staff as 38 of the 40 people need two members of staff to assist them with personal care and to get out of bed. It's very hard as we can't give the level of care that we want to. Normally most people have a bath once a week but that's not always possible. You just don't get the job satisfaction as it's such a rush. It has a knock on effect as if people get up late they then don't want their lunch as they have only just had breakfast." One person confirmed this and told us, "Having a bath is a bit hit and miss because once I didn't get a bath for three weeks, just a wash." The records showed that although people had requested a bath once a week this was not always being achieved.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the medication administration records and storage of medication and found significant concerns. We were not confident that people always received their medication as prescribed. Records and staff confirmed that two people who had been due to have a three monthly injection of Neo-Cytamen (Vitamin B12) in May 2016 had not received the injection. This omission had not been identified by the staff.

The medication administration records (MARs) for one person showed that they had potentially not received their medication for diabetes for four consecutive nights. We checked how many of the tablets were in stock and found that there were three more tablets in stock than there should have been. One nurse told us that she had given one of the tablets but had forgotten to sign the MARS but could not account for the other tablets. This suggests that the medication had not been administered for three of the dates when they should have been This issue had not been identified by any of the nurses who were responsible for administering medication. We checked the MARs for two people and found that there were seven omissions of signatures. There was no explanation on the reverse of the record to give the reason for the omissions. The records and stock of medication for one person showed that there was one less tablet in stock than there should have been. Failure to administer people's medication as prescribed could have a serious effect on the health and well-being of people.

People's care plans stated, "I require a registered nurse to administer my medications as prescribed by the doctor and according to the NMC [nurse and midwifery council]. The nurse will require updating yearly (training) and competency monitored (see training matrix)." However the registered manager confirmed that the competency of the nurses to administer medication had not been assessed.

The registered manager stated that a monthly medication audit was carried out by a member of staff. However when we spoke to the member of staff they stated that they had not been made aware that it was their responsibility to complete the medication audit. The monthly medication audit had not been completed since April 2016. The registered manager stated that she had not been aware that the monthly medication audit had not been carried out in May or June 2016. The monthly medication audit completed in April 2016 showed that it was semi compliant with the policies and procedures. There was no information on the audit to show what action had been identified. The registered manager was not aware if action had been taken to address these issues. Failure to carry out these audits meant that the issues we identified regarding people not receiving their medication as prescribed had not been highlighted and could have continued to be a risk to people.

The registered manager stated that the nurses were responsible for carrying out an audit and stock check of the controlled drugs on a weekly basis. However these had not been carried out on a regular basis. The nurses that we talked with were not aware that it was their responsibility to carry out an audit or stock check of the controlled drugs. We found that there was an ampoule of diamorphine in the controlled drugs cabinet and that it was not possible to identify who it had been prescribed for. The nurses and the registered manager had not identified that this was an issue. One care assistant stated that they had been asked by the nurse administering medication to be the second witness for the administration of a controlled drug. The care assistant stated that they had not received any training to do this.

We saw that on two occasions during the inspection the door to the treatment room was left open and no staff were in the room. This gave people access to diabetic equipment, syringes, prescribed nutritional supplements and dressings. We also saw on one occasion that the keys were left in the medication trolley whilst the nurse was out of sight in someone's bedroom administering their medication.

This was a breach of Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager stated prospective new staff were required to complete an application form and attend an interview before they were offered a position in the home. The registered manager also stated that two satisfactory written references and a DBS check (check of criminal convictions and barred lists) was required before new staff commenced working in the home. We looked at the recruitment records for the

three most recently recruitment members of staff. There were no records of the DBS checks on file for the three records we looked at. The registered manager was not aware that there were no DBS checks on file for the three members of staff. The registered manager stated that the provider normally carried out the DBS checks. We also noted that information for one of the staff members showed that their registration with the Nursing and Midwifery Council as a registered nurse had expired. There was no evidence that it had been renewed. The registered manager was not aware that the nurse's registration had expired. The registered manager stated that it was their policy to receive two satisfactory written references before new staff commenced working in the home. However one of the three staff records showed that there was only one reference on file when the staff member commenced working in the home' The registered manager stated that she had allowed this to happen as she knew the member of staff. This meant that we could not be confident that action had been taken to ensure that the right people were always employed. This could place people at risk of being cared for by staff that were not appropriate to work with vulnerable people.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection we asked to see the fire risk assessment. The only one that could be found was dated July 2009 and had not been reviewed since July 2011. A recent fire risk assessment was found on the second day of the inspection. The records showed that the fire alarms were being tested weekly. However there was no certificate to show that the fire alarm system had been serviced since 2014. A representative of the provider stated that it had been serviced in 2015 but no certificate had been provided. A new fire alarm system was in the process of being fitted.

There were no personal emergency evacuation plans (PEEPS) in place for anyone in the home. There was no provision to evacuate people that were being cared for from the first floor. The manager stated that in the event of a fire people would be moved behind fire doors and they would rely on the fire service to evacuate people. Staff told us they were not aware of the procedures to follow if they needed to evacuate people from the first floor and that there was no equipment available to help evacuate people that could not walk. It was not clear from the records which staff had completed fire training. A representative of the provider was responsible for training staff about the evacuation procedure. However there was no plan in place to ensure that all staff had received the training and were competent.

Because of our serious concerns regarding the fire safety we contacted the local fire service who agreed to visit the home the following day to inspect the provision in the event of a fire. The fire officer was also concerned that there was no means of evacuating people from the first floor if they could not walk down the stairs and regarding the absence of PEEPS.

The lack of clear information about people, fire procedures, staff training and fire evacuation equipment meant that people living at the home were at significant risk in the event of a fire. We told the provider they must take immediate steps to rectify this issue.

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

One person that we talked to stated, "I do feel safe here because of the staff. They keep me happy and see to my needs." Another person told us, "I've been here over six years and I feel safe here because the staff are so nice."

Staff told us and records confirmed that staff had received training in safeguarding and protecting people

from harm. A safeguarding policy was available and staff told us that they had read it. Staff were knowledgeable in recognising signs of potential abuse. However not all staff were aware of the correct procedures to follow if they suspected a person had suffered any harm. For example, some staff told us that they would start to investigate an allegation first rather than reporting it to the relevant safeguarding authorities for guidance on the appropriate actions to take. This was not in line with local authority safeguarding advice and puts people at risk that investigations could be compromised and inadequate action taken to keep people safe.

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

During the previous inspection in October 2015 it was stated that further improvements were needed to ensure that risk assessments included information about how risks to people should be reduced. Before this inspection we received information of concern about the safe use of bed rails. We found that risk assessments had been completed for their use, although these were basic and did not identify additional risks when pressure relieving equipment was used that reduced the height of the top of the bed rail. This put people at an increased risk of injuries. Not all of the bed rails had been fitted to comply with guidance from the Health and Safety Executive and this also put people at risk of entrapment.

Our investigation showed that falls had occurred from beds where bed rails had been used. After we identified these concerns we asked the provider to take immediate action to ensure bed rails provided to people were safe. This included that bed rails complied with correct fitting guidance and that when other equipment was used, additional assessments were completed to reduce any risk associated with this. During our visit we found that action had been taken to do this; bed rails that had been identified as incorrectly fitted were replaced and more detailed risk assessments had been completed to show rails had been fitted correctly. These assessments also identified risks associated with additional equipment and whether further action was needed to keep the person safe.

Accident and incident forms showed that risk assessments had been updated after people had fallen. However the registered manager had not analysed the accident or incidents which would have allowed them to identify if there were any themes and take appropriate action if needed.

Requires Improvement

Is the service effective?

Our findings

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We inspected the home in March 2015 and October 2015 and rated the effective domain as, "Requires Improvement" on both occasions. In March 2015 we found there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to Regulation 11 of the Health and Social care Act 2008 (Regulated activities) Regulations 2014. We stated that, "Issues of consent were not fully understood". During the October 2015 inspection we found that not all staff had received training about the Mental Capacity Act and Deprivation of Liberty Safeguards and the staff understanding of how to put it into practice was variable. The report also stated that improvements were needed to ensure that the records were updated to clearly show that where decisions had been made for people that this had been done in their best interests and with the involvement of the appropriate people.

During this inspection we checked to see if improvement's had been made. We checked whether the service was working within the principles of the MCA. The registered manager had made several DoLS referrals. However when we asked to see the capacity assessments for these people we were told that they had not been completed. The registered manager stated that if someone had a diagnosis of dementia then they were assumed to not have capacity to make any decisions. The registered manager did not understand that capacity assessments and best interest decisions should be considered individually and the appropriate action taken.

We found that capacity assessments, best interest decision and DoLS applications had not been completed accurately or in line with the principles of the MCA. DoLS referrals had been made for two people and stated that they did not have anyone whom it was appropriate to consult with about their best interests. However both people had regular contact with their immediate family members. We saw that a 'best interest' decision had been made about the use of bed rails for one person. However a mental capacity assessment had not been completed for the decision to be made. This is not in line with the principles of the MCA.

Staff told us that they were not aware of the principles of the MCA or how it affected the people they were working with. They told us that they tried to give people choices where possible and asked them if they could carry out personal care tasks. Staff were not aware if any best interest decisions had been made for anyone living in the home. One nurse told us that although they had been expected to complete a DoLS referral for someone they had not completed any DoLS or MCA training and were not aware of what they

needed to do. Although the registered manager had identified in January 2016 that nine people needed a DoLS application, two still had not been completed by July 2016. This meant that decisions were taken on behalf of people without the necessary processes being followed. This also meant that people were possibly being deprived of their liberty without the necessary safeguards being in place.

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

During the October 2015 inspection we found that it was not always clear what training agency staff had completed or if their competency levels had been checked. During this inspection we found that although the home was using a considerable amount of agency staff each day to cover staff vacancies there remained no process in place to check if they had the right training. The registered manager stated that there was an induction booklet for agency staff that had not worked in the home before. The new member of agency staff was expected to work through the booklet with an experienced member of staff. The induction included information such as, Introduction to staff and people, fire procedures and exits, call bell system, confidentiality, safeguarding procedure, health and safety procedures and people's rights.

We asked to see the completed induction booklet for four members of agency staff who had worked the weekend previous to the inspection visit. However the registered manager stated that they had not been completed for any of the four members of agency staff because, "They are not completed straight away, it depends how busy the shift is." However two of the four staff had worked at the home for over two months, one for a few weeks and the fourth one for three shifts. The registered manager stated that there was also another member of agency staff who had worked at the home for over 18 months but they had also not completed an induction booklet. This meant that people were being cared for by staff who had not received the correct training. This could place people at risk of receiving care and support from staff that do not have the necessary knowledge and skills to meet their needs.

The registered manager stated that all new permanent staff completed an induction booklet. The registered manager said that newly recruited nurses worked through the induction booklet with either the registered manager or the senior nurse within a month and the care assistants had two months to complete the booklet. However, for the two most recently recruited nurses only one of them had completed an induction booklet. The other nurse stated that they had not had an induction or seen a booklet. The registered manager could not remember if she had been responsible for going through the induction with the new nurse or if she had delegated the task to a senior nurse. We also saw an induction booklet for a new care assistant who had commenced working in April 2016. Some areas of the induction booklet had been signed by the care assistant, while other areas were still blank. No areas of the booklet had been signed by the person responsible for going through the subjects with the care assistant to say that it had been completed. The induction booklet stated that the purpose of it was to "enhance the quality of the care provided to people in the home" and to "enable them [staff] to provide good quality care and safe work practices". The induction included basic information such as introduction to people, health and safety issues, policies, confidentiality, resident's rights and safeguarding vulnerable adults. This meant that staff were expected to start working in the home without completing the necessary training or having a through introduction to the home. This placed people at risk of receiving care that did not meet their needs.

The registered manager stated that she expected all staff to complete fire training with the local fire service which included how to use equipment once every two years. She also stated that staff were required to complete in-house fire training every six months. The in house training was delivered by a representative of the provider. However not all staff had attended the fire training. On the first day of the inspection we enquired if the staff working that night had completed the fire training. The registered manager checked the

records and found that none of the staff that were due to be working the night shift had completed the in-house training. As the person who delivered the fire training was in the building we advised them that they should ensure that staff had the relevant training so that they knew what to do in the event of a fire.

The registered manager stated that an online learning system had been introduced to the home two years ago but the staff had only commenced using it in the previous six months. The training records and discussion with the registered manager and staff showed that not all staff had completed the training that was required to carry out their role effectively. For example, for one nurse who had commenced working in the home in 2015 there was no record of them completing training in the fire procedure, health and safety, mental capacity act awareness and safeguarding people. The nurse confirmed that they had not completed the training. We could not be confident that all staff had received the training they required for their roles.

During the March 2015 inspection we found that we could not be assured that nursing competencies were being monitored appropriately. During this inspection we checked to see if improvements found during the October 2015 inspection had been maintained. The registered manager stated that there were competency assessments for the nurses regarding changing a catheter, venepuncture, subcutaneous fluid infusion and administering medication. However of the 14 nurses employed at the time of the inspection only one competency assessment had been completed for one nurse. The nurses confirmed that although they had not been assessed as competent to carry out nursing tasks within the home they were still carrying them out. The registered manager stated that the competency assessments had not been carried out due to time constraints. This meant that there was a risk that nursing tasks could be carried out incorrectly.

Staff were not required to renew training if they stated to the registered manager that they had completed it in their previous employment. However, no proof of the training had been requested and evidence that they were competent in these areas had also not been provided. This meant that there was no information about the suitability of the previous training or if the member of staff had been deemed competent in that area.

During the inspection in October 2015 staff told us they had, very recently, started to have formal supervision sessions at which they could discuss their work and any development needs. During this inspection we checked to see if the improvements had been sustained. Not all nursing staff and care staff were receiving regular supervision sessions. The registered manager stated that they aimed to complete a supervision session with all staff once every two months but that "due to time constraints" this hadn't always been achieved. The supervision records we looked at showed that a nurse that commenced working in October 2015 had not received any supervisions. The supervision matrix supplied by the registered manager indicated that five of the 14 nurses employed had not received any supervisions in 2016. One nurse told us that they had not received a supervision or appraisal within the previous 12 months. The registered manager had not received any supervisions from the provider in 2016.

This meant that staff did not always received the training, supervision and support they required to carry out their roles effectively.

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

People were supported to maintain a healthy diet. One person said, "The meals generally are good – I have two Weetabix for breakfast and toast too. There is fresh fruit available if I want and I like my veg and do have it with every meal." Another person told us, "I get plenty of drink and there is always something on my table here." A third person told us, "I do get snacks between meals and there are biscuits and crisps and you only have to ask or sometimes they ask me."

When appropriate, people were supported to eat their meals and adapted plates and cutlery were provided. If needed people had been referred for eating and drinking assessments to see what support they required with their food and drink. When people did not like their food they were usually offered another choice although we saw that this did not always happen. The records showed that people's weight was being regularly monitored and appropriate action had been taken when needed. Some people had food and fluid charts that staff were expected to complete so that their intake could be monitored. However, the food and fluid charts had not been completed with enough details. For example, portion sizes had not been recorded. We observed during lunch time that different people had different portion sizes. This meant that staff did not always have the necessary information so that they could take the appropriate action if people had not consumed enough food and drink.

Discussion with people and records showed that people had been supported to access health care professionals as needed. Where issues with people's health had been highlighted the records showed that they had then seen the GP or referrals made to relevant health care professionals. This included appointments with dieticians, speech and language therapist, occupational therapist and diabetic nurses. However, we received information from a healthcare professional that people's individual needs were not always being met. One person had not received the appropriate wound care or personal care in a timely manner.

Requires Improvement

Is the service caring?

Our findings

During our previous inspection in October 2015 we found that people had to wait for assistance to use the toilet or other aspects of personal care which meant that on occasions their dignity was compromised. We checked to see if improvements had been made during this inspection and found that the issue still remained . One relative told us, "What I'd say is bad about the place is the poor response to calls. We know people wait an age and the staff just say they are understaffed." Another relative stated, "The staff are kind but there is a terrible shortage of them in my opinion. They (the staff) can be a bit rude if I challenge them about things not being done." One person told us, "I do get downstairs sometimes, but I don't like to because the staff won't bring me back up again until they are ready." People's dignity was compromised because they had to wait for long periods for assistance with personal care and to help them to the toilet. People also could not choose to get out of bed when they wanted to as they had to wait long periods before staff were available to assist them.

Some people told us that they thought the staff were caring. One person told us, "They [staff] are very kind and do listen to me all the time. We talk about old times." Another person told us, "I've had people (staff) ask me about the care home and I told them I like it here because it's friendly and caring." One relative told us, "I would say [family member] is treated with dignity and respect, yes."

Staff told us that they tried to offer people choices in way that they understood. For example, one person had a flip chart with different pictures so they could point at what they wanted. However, the lack of understanding about the application of the MCA and DoLS meant that people were not being asked to consent to decisions or where they may not have the capacity to consent to certain decisions the appropriate action had not been taken. One person confirmed that they had been involved in making decisions about their care. They stated, "From what I remember I have seen my care plan and it's talked over with me because of my ongoing condition." However, other people were not aware of what a care plan was. One relative stated, "I've never seen a care plan and I'm pretty sure [family member] hasn't either." The person also confirmed that they didn't know what a care plan was. Another relative stated, "I don't think the staff involve me in[family member's] care at all."

One member of the care staff told us how a person had told them that they really fancied a certain take away so they had gone and purchased the food for them. One person told us, "The people (staff) here are always friendly and respectful and I get on with them very well."

We observed staff working with people in a kind and caring manner. We observed lunchtime and saw that staff were polite and attentive. One member of staff kneeled down when they were talking to a person so they were the same height. They responded quickly when the person asked them for different items. Staff asked people if they would like condiments on their meals and assisted people with them when asked to. One person told us, "I find the staff kind and nice here and will always get me something if I ask."

People told us that their family and friends could visit at any time. One person told us, "My family do visit me regularly, once a week if possible and they come and go when they want." A second person told us, "My

daughter comes in quite a lot to see me when she wants and I like seeing her."

Requires Improvement

Is the service responsive?

Our findings

We inspected the home in March 2015 and October 2015 and rated the responsive domain as, 'Requires Improvement' on both occasions. In March 2015 we found there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Although some improvements had been made at the October 2015 inspection the home still remained in breach of the regulation and further improvements were required. An action plan was provided by the registered manager which stated that action would be taken by 29 February 2016 to ensure that person centred care plans were in place so that people's individual preferences were met. However we found that not all care plans recorded the information that staff required to meet people's individual needs. We also found that people were not always receiving the care and support required in the way they preferred.

People's care needs were assessed before they went to live at the home. We saw that these assessments contained adequate information to determine whether staff were able to meet their care needs. Information was also obtained from health care settings, for example, where people had been admitted straight from hospital. One person also had detailed information from specialist medical services about their abilities and limitations in relation to caring for themselves.

The level of detail in some care plans had improved so that they contained most of the information that staff required. Some care plans only provided basic information, while others told a story about the person and gave a sense of who that person was, what they wanted and how they preferred to be cared for. For example, one care plan included detailed information about the methods of communication the person used. It described what the physical signs were that they were in pain, such as rubbing their right arm.

We saw, however, that there were some care plans that needed additional information so that staff members had all of the appropriate guidance to make sure the person's care was as personal to them as possible. One care plan for diabetes contained no information about the person's usual blood sugar range and a nurse who was responsible for caring for the person also did not know what this was. This meant that the person was at risk of not receiving the care they needed as if staff were not aware of what the person's blood sugar levels should normally be they may not be aware if it fluctuated and therefore may not take the right action. A care plan for social interaction showed that the person liked to watch television but it did not include which programmes they liked to watch. Care plans for people living with dementia did not include information about how the dementia affected them on a daily basis. For example, one person's care plan stated that their dementia had a, "Massive impact" but did not describe how or what action staff should take to support them with these issues. This meant that the person was at risk of receiving care that was not personalised and did not meet their individual needs. The care plan for one person stated that they had capacity to make some decisions, however there was no information about what decisions staff could enable and encourage the person to make. This could mean that the person was not consistently encouraged to make decisions that affected them even though they were able to.

We spoke with staff members who were able to tell us about people's individual care needs and showed

that they knew people well. However they told us that they couldn't always meet people's needs in the way that people preferred due to time restraints. Staff said that they found this frustrating and raised the issue with the management and providers on several occasions. For example, staff told us that although they were aware that people liked to have baths and showers regularly they did not always have the time to carry this out. Staff were able at times to anticipate people's needs and most of the interaction that we saw showed that staff involved people in their care decisions. We saw that staff asked people what they would like and allowed them to decide. However, there were occasions when staff members did not involve people and made decisions that ultimately the person did not like. We saw this during one lunchtime meal when staff were discussing one person's ability to swallow and which dessert would be most appropriate. The decision was made to give the person the sponge option, which the person subsequently did not want or did not like and declined to eat the dessert. The person was then offered an alternative, which they did eat.

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

One member of staff was responsible for organising the activities in the home. They helped people to plan and co-ordinate activities according to their interests. Group activities in the communal areas were carried out and for people who preferred to stay in their rooms the activities coordinator also spent individual time with them. Activities included bingo, reminiscence, cooking, exercise, religious services and arts and crafts sessions. However one member of staff stated that the staffing levels were having an impact on people attending the communal activities sessions. One relative had complained to the member of staff as their family member suffered with depression and liked to be involved with the activities but wasn't always helped out of bed in time to attend the morning sessions.

One relative told us, "I don't feel the manager listens to my complaints about my [family member's] care and when I point out errors in their care she has told me she needs the names of staff to take action." One person told us, "I never complain about anyone or anything, but since you ask I'm not sure how I would go about it." Another person told us, "If I had a complaint then I'd tell the first person I saw, but I do express my views about how I feel and the staff act on it. I always tell them if I'm in discomfort and they will move me in the bed."

Inadequate

Is the service well-led?

Our findings

During the previous inspections in March 2015 and October 2015 we found that there was a breach of legal requirement regarding the quality assurance process in place. The registered manager wrote to us and told us about the action they were going to take and that they would be compliant with this regulation by 29 February 2016. However during this inspection we found that the quality assurance system in the home was still not effective in driving continuous improvement in the home.

We asked the registered manager how she had been proactive in ensuring that the home was compliant with the Health and Social Care Act 2008 and the associated regulations. The registered manager stated that they had read the regulations but had not done anything proactively as they relied on the inspections carried out by the Commission to identify any issues.

Individual care plan audits had been completed. However, although they had highlighted areas that needed updating or completing these had not been done. For example, one care plan audit was completed in April 2016 and identified that the person's family needed to attend a review, a DoLS referral was needed and information about the person's history was required. We asked the nurse who was responsible for the person's care plan if the actions had been completed and they confirmed that none of them had. The nurse also stated that they did not know how to complete a DoLS referral so they would not be able to do that. This had not been identified as an issue by the registered manager even though it had been raised in a previous inspection. This failure to complete the actions meant that people may continue to receive care that was ineffective or unresponsive to their needs.

During the March 2015 inspection we identified that although there was a medication audit process in place this hadn't been completed for the previous five months. During the October 2015 inspection we identified that although medication audits were taking place they were still not effective. At this inspection we found that staff were not aware of the registered manager's expectation of them to carry out certain audits. There was no process in place to ensure that these delegated audits had been completed. When audits had not been completed as expected no action had been taken by the registered manager to ensure they were completed. This meant that issues had not been identified that would have required action to be taken. For example, no medication audits had been completed since April 2016. Therefore until we identified it as part of the inspection no one had identified that two people had not received their three monthly injection that was due in May 2016. The lack of regular audits had been raised previously during the inspection in October 2015. This meant that the auditing system in place was not effective at identifying risks to people and did not prevent the same issues from reoccurring.

Regular staff meetings were being held and staff members confirmed that they could add to the agenda. The records showed that poor practice issues were raised during the meeting. One member of staff told us that they had raised an issue several times in the meetings but it had not been resolved.

We asked the registered manager what the aims and philosophies of the home were. The registered manager stated, "That people are happy and safe at the home. That staff are trained and able to carry out

their roles." The registered manager stated that she made staff aware of the aims of the home by providing them with training in dignity and respect. However we found that that there were not effective processes in place to ensure that people were safe and that the staff were competent to carry out their roles.

There was no clear plans of which member of staff was responsible for the induction of new nurses. The registered manager was not able to tell us if they had been responsible for the induction of a nurse that had commenced their employment in October 2015 or if they had delegated the task. However the new nurse had not received an induction. The registered manager stated that as competency assessments had not been carried out for the majority of the staff, she was not able to say they were competent in their roles. No action had been taken by the registered manager to ensure that staff members received regular supervisions and appraisals. There was no process in place to make sure that when the registered nurses' pin number expired that it had been renewed. This meant that people were being cared for by staff that may not have the right skills, training or knowledge to meet their needs.

There were competency assessment forms for nursing duties. However only one assessment had been completed. The registered manager told us that these had not been completed due to time constraints. There were no plans in place to complete the other assessments with the nursing staff. The nurses on duty confirmed that they were carrying out the nursing tasks. This put people at risk of receiving care from staff that were not competent to carry out certain tasks.

There was no training plan for the coming year. The registered manager stated that staff were expected to complete e-learning courses on the computer and some classroom based training. However there was no information so that staff knew how often they were expected to complete each training course. There was no training plan in place for the future. For example, the registered manager stated that although the majority of staff would need training in basic life support in August 2016 because their previous training would expire she had not organised any further training. Although there were dates recorded on a training matrix when staff had completed training, no action had been taken in response to the staff that had not completed their training as expected by the registered manager. A representative of the provider was responsible for training staff on the fire procedure and fire panel. However when we asked why one member of staff had not completed the training they told us, "Because that member of staff works weekends and I'm not here at weekends." No provision had been made for staff that only worked weekends to complete the fire training.

One member of staff told us that they had experienced problems trying to alert other staff to a medical emergency in a person's room because there were not enough pagers for the call bell system. The registered manager stated that the home normally had five pagers for staff to carry to alert them when a person used their call bell to request assistance. The registered manager stated that one pager had been lost and one had been sent for repair. However when we enquired with the staff on shift how many pagers were available only two could be found. More pagers were ordered during the inspection. This had not been identified as a problem or dealt with before the inspection. The lack of pagers had increased the risk of people not receiving care when they needed it.

The registered manager and representative of the provider stated in the provider information return that only one complaint had been received in the previous 12 months. We asked to see the details of the complaint and were given a list of complaints that had been received since January 2016. Five complaints had been recorded as being received. The registered manager stated that she thought only, "Serious complaints" had to be recorded in the PIR. The registered manager could not confirm if all of the complaints received had been investigated. We asked to see what complaints had been received before January 2016. However the registered manager stated they had not been recorded on a complaints log so they only way

on knowing was to look through everybody's care plans to see if they had made a complaint. The registered manager stated that they did not monitor complaints over time to identify trends or areas of risk so that they could be addressed. We could not assess if all of the complaints had been dealt with appropriately and to the satisfaction of the complainant because there were no written details of the complaint, investigation and outcome for some of the complaint's received.

Although it had been identified during the two previous inspection in March and October 2015 that people's needs were not being met in a timely manner this continued to be a major issue. Staff told us that they had discussed the insufficient staffing levels with the registered manager and provider on several occasions. Staff told us that they had been told by the provider that there were insufficient funds to increase the staffing levels. On the day of the inspection a representative of the provider stated that they had been told by the registered manager and the staff that staffing levels were insufficient.

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

Staff told us that they could approach the registered manager with any concerns. They also said that they were aware of the whistleblowing policy and would report any concerns about staff practice to the registered manager.

Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service. We use this information to monitor the service and ensure they responded appropriately to keep people safe. The registered manager had normally submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance. However we did see a record that said one person had fallen and had broken their hip. However the accident form for the person stated that they had fallen and only sustained grazes to their head and knee. When we asked the registered manager about this they stated that the accident form hadn't been updated and they would need to notify the Commission as required that there had been a serious injury sustained.

The registered manager stated that a quality assurance questionnaire had been left in everybody's room to complete about the service they received. However, no provision had been made for those people who may need help completing the questionnaire. No provision had been made to send a questionnaire to people's relatives, other stakeholders or staff members. Only eight questionnaires had been returned, although the majority of the comments were positive.