Berengrove Limited

Berengrove Park Nursing Home

Inspection report

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Gillingham
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place over two days, 15 and 16 August 2017. The first day of the inspection was unannounced. This was a planned comprehensive inspection to follow up from the previous inspection report when we had found four breaches of the regulations

Berengrove Park Nursing Home is registered to provide accommodation for older people who require nursing or personal care. The home could provide care and support for up to 36 people. There were 32 people living at the home at the time of this inspection. People had complex health needs, including diabetes, stroke and Parkinson's disease. Many people were living with dementia, some at an advanced stage requiring high levels of support from registered nurses and staff.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our last inspection report of this service was published on 06 July 2016 and related to an inspection that had taken place on 12 and 13 April 2016. At the inspection in April 2016 we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to; Regulation 12, hazards had not been fully identified and managed, meaning people, staff and visitors were at risk of potential harm; Regulation 15, people who use services and others were not protected from the risks associated with unsafe or unsuitable premises because of inadequate cleaning and maintenance; Regulation 17, the provider had failed to ensure adequate auditing and monitoring were in place to check the safety and quality of the service provided. We also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, CQC had not been notified of important events that had taken place in the service. We asked the provider to take action to meet the regulations.

The provider sent us a report of the actions they had taken to comply with Regulations 12, 15 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on 08 July 2016 and they told us they were already meeting the Regulations. They also said they had taken action to meet Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection we found the provider and registered manager had made some improvements to the service and standard of care. However, we found improvements were still required and found a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found new breaches of Regulation 9, care and support was not always provided to meet all the needs and preferences of people; Regulation 10, people's privacy and dignity were not always respected; Regulation 12, risks were not always assessed, reviewed and monitored; Regulation 18, staff were not suitably deployed to ensure people's needs were sufficiently met.

Risk assessments around people's personal and nursing care needs were in place. However, risks were not always reviewed to take into account people's changing needs or incidents that had happened.

Staff were not deployed sufficiently around the service to ensure people's care and support needs, including social and welfare needs, were met. People were often left sitting on their own in the lounge or in their bedroom with little stimulation. People were not engaged in meaningful activities that were based on their interests and to create a motivating environment.

People's care plans were suitable for their personal care and nursing needs. However, care plans were not person centred or focussed on people's well-being and social and cultural needs or based on their preferences and interests. People and their relatives were not always involved in reviewing their care plans.

Plans in place to provide meaningful activity were not adequate to meet the needs of people, to provide social stimulation and to maintain the emotional well-being of people. People were left alone with little interaction for long periods of time.

Mental capacity assessments had been undertaken within the principles of the Mental Capacity Act 2005 and best interests decisions had been made around people's nursing and personal care needs. However, some important decisions had not been considered which constituted a contravention of people's basic rights. We have made a recommendation about this.

Daily records, including food and fluid charts, bowel recording charts and activity records were not recorded consistently so not showing a complete and accurate record. Although an audit and monitoring system was in place it was not used effectively to identify concerns and act on them to drive improvements within the home.

The provider had asked for feedback of the service from relatives and professionals involved in the service. There was no evidence that some comments made had been listened to and actioned.

The registered manager had not received regular one to one supervision to provide them with the support required to provide good management and leadership. We have made a recommendation about this.

Staff were complimentary about the registered manager, the provider and the nurses and said they would take any concerns they had to any of them.

The provider had robust recruitment processes in place to make sure only suitable staff were employed to work in the service.

Staff had regular one to one supervision meetings with their manager to support their development. Suitable training was provided and staff received the appropriate refreshers and updates. New staff received a good induction into the service and experienced senior care staff supported the first weeks in their new role. Staff were kind and caring in their approach.

Staff meetings had not taken place for over one year. We have made a recommendation about this.

Complaints were dealt with by the provider. Records were kept showing the action taken and the outcome to the complaint.

People received their prescribed medicines by registered nurses. The medicines administration process was

managed well, including the ordering, storage and return of medicines in the home.

The provider had a safeguarding procedure in place so staff could access the information they needed to protect people and raise concerns.

People and their relatives said they were happy with the food provided. The food looked attractive and menus were nutritious and varied. No people sat at the two available dining room tables and people were not given the choice whether they wanted to. We have made a recommendation about this.

People's health needs were generally taken care of by the registered nurses working in the home and GP practices. Health referrals had been made as appropriate to other health care professionals.

The trip hazards that meant people, staff and visitors had been placed at potential risk of harm had been removed and electric lights were now working correctly. Maintenance of the premises and servicing of equipment had been carried out as required.

Cleaning schedules were in place, hoist slings were now used for one person only and the nurses clinical area had been cleaned and refurbished.
The provider now made sure they notified CQC of any important events that happened in the service as they are required to do.

We found five 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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some risk assessments were in place to identify and minimise risks to people. These were not always reviewed to take into account people's change in circumstances or following an incident.

Staff were not deployed appropriately to ensure the correct levels of care and support was available to meet people's needs.

Robust recruitment processes were in place to ensure staff were of suitable character to work with people living in the service.

Accidents and incidents were recorded by staff but not always managed effectively to prevent future occurrences.

The management and administration of people's medicines was managed well by registered nurses.

A safeguarding procedure was in place to provide information about staff responsibilities to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported appropriately to ensure their basic rights were upheld within the principles of the Mental Capacity Act 2005.

People were happy with the food and dietary requirements were met. People did not have the opportunity to choose if they wanted to sit at a dining table.

People's basic health needs were met and referrals made to specialist health care professionals.

Staff received one to one supervision and accessed their basic training requirements.

Is the service caring?

Requires Improvement

The service was not always caring.

People were left alone either in the lounge or their bedroom for long periods of time with little social interaction.

People and their relatives were not involved in reviewing their care plan to make sure all their needs continued to be met.

People had not been given a choice to have window coverings to maintain privacy and dignity.

Staff observed people's privacy by knocking on their bedroom doors before entering. Staff spoke to people in a respectful and caring way.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care given was not person centred. People did not always have their preferences about their care and support recorded.

People did not have an individual plan to make sure their interests were documented so meaningful activity could be provided. Activities were not planned to create a motivational and socially interactive environment.

Relatives were asked their views of the service provided, however some comments had not been listened to and actioned in order to make improvements.

A complaints procedure was in place and informal complaints had been dealt with quickly and appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Quality monitoring and assurance processes continued to not be effective in identifying and rectifying areas that required improvement.

Daily records were poorly kept.

Staff meetings had not been held and the registered manager had not received one to one supervision.

Staff described the registered manager and provider as approachable.

Berengrove Park Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 16 August 2017. The first day was unannounced, we told the provider that we would return on the second day.

The inspection team consisted of one inspector, one specialist nurse advisor, who was a registered general nurse, and an expert by experience. The expert by experience talked to people and visitors to gain their views of the service provided. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the previous inspection report and the provider's action plans. We also looked at notifications the registered manager had sent to CQC. Notifications tell us about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

We spoke with ten people who lived at the service and five relatives to gain their views and experience of the service provided. We observed the care given to the people living in the service. We also spoke to the registered manager and eight staff including registered nurses, care workers, domestic staff and the cook. We also gained feedback about the service from two community nurses, one independent health care professional, one local authority care manager and another local authority officer.

We spent time observing the care provided and the interaction between staff and people. We looked at eight people's care files, activities records, medicine administration records, four staff recruitment records and

three further staff records to check supervision and training and the staff rota's. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at feedback given by relatives and professionals through questionnaires the provider asked them to complete.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 12 and 13 April 2016 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to; Regulation 12, Safe care and treatment. Hazards had not been fully identified and managed meaning people, staff and visitors were at risk of potential harm; Regulation 15, premises and equipment. The premises and equipment were not of an acceptable standard of cleanliness, people were at risk of infection by the lack of robust cleaning schedules and the lack of monitoring. We asked the provider to take action to meet Regulations 12 and 15.

Following the last inspection the provider sent us an action plan on 08 July 2016 stating they had already taken action to improve the service and now met the regulations. At this inspection we found some improvements to the service. The hazards within the property at that time had now been removed. Hoists and other equipment that were stored in hallways and corridors causing a risk of potential harm were now kept in more suitable places. The clinical room used by the nurses had been refurbished and a cleaning schedule was now in place. The kitchen staff had cleaning schedules that were checked by the provider or registered manager. People who required the use of a hoist, to mobilise from their bed to a chair for example, now had individual slings that were kept in their bedrooms. However, we could not find a record of how often the slings were laundered. When we asked a member of staff they said they were washed about once a month. The provider had commenced a programme of refurbishment and although on-going had made a number of improvements. However, we found other areas of concern at this inspection.

The provider had individual dependency tools in place to assess the level of dependency of each person. The assessments were in the form of a tick box and scoring mechanism. For example, staff ticked to show if people needed one staff or two to mobilise or were nursed in bed, or if they were at risk of falls. We asked the registered manager and provider what purpose these were used for and they told us they gave the care staff information about people's needs. The dependency assessments were not collated together to establish the needs of the people living in the service, assisting the provider and registered manager to assess the numbers of staff needed. The provider and registered manager said they had enough staff to meet people's needs and if they had a shortage they used agency staff. However, our observations during the inspection were that there were not enough staff suitably deployed to meet the needs of people living in the service. Some people nursed in bed did not receive their morning care until late morning or lunchtime. Curtains in the bedrooms of some people nursed in bed were not drawn until late morning. Apart from when people were having their personal care needs attended to by staff there was no interaction with people in their rooms. People sitting in the lounge were left for long periods of time with little or no staff interaction. We had to go to find a member of staff when one person sitting in one of the lounges was trying to get out of their chair, saying they had a pain. When a member of staff arrived the person repeated they were in pain. The member of staff said they would get a nurse. No nurse arrived. The person later told the domestic staff they were in pain, the domestic staff member went off straight away to alert a nurse. However, a nurse did not arrive before we left the lounge area forty minutes later. This meant that people were at risk of harm, such as falls and they experienced delays in having their care needs attended to.

The failure to suitably deploy sufficient staff to meet all of the assessed needs of people living in the service

is a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated Activities) 2014.

A registered nurse was required to be on duty in the service at all times due to the nature of people's nursing needs. The provider had 'bank' nurses on their rota. These are nurses who do not work regularly at the service but cover when they are required. Some bank nurses choose to do this due to their family commitments and others because they have a permanent place of work elsewhere and do this as extra hours. Some bank nurses worked as little as one shift every two weeks. The registered manager told us having bank nurses meant agency nurses were used rarely. Agency workers were being used regularly to cover care staff absences and vacancies.

Accidents and incidents were recorded by staff when incidents happened. However, there was no evidence that these had been monitored and we saw some incidents that had not been followed up by the registered manager or the nursing staff. One person had fallen out of their chair twice, on 03 August 2017 and 11 August 2017. No record was made of the action taken or whether care plans and risk assessments had been updated. We checked the person's care plan. A falls risk assessment dated 07 July 2017 stated that they required a hoist to assist with moving from bed to chair and vice versa and showed they had a history of falls when transferring. Neither of the falls had happened during transfer, the person had slid out of their chair on both occasions. Care plans and risk assessments had not been reviewed as a result of these incidents. This meant that measures had not been put in place to minimise the risk and staff had not been given up to date guidance on how to keep the person safe from falls.

Nursing care risk assessments had been undertaken to minimise the risks of; pressure sores, falls, malnourishment, using bed rails and social isolation. Identified risks were recorded and the control measures and action required to minimise the risk were documented. These risk assessments were reviewed regularly. However, we found that reviews were not always identifying changes in people's needs or circumstances. For example, the person who had slipped out of their chair on two occasions did not have an updated risk assessment in place to minimise the risks now posed by this change. Staff were not always using the control measures to minimise risks. For example, one person who was nursed in bed and was also hard of hearing had a risk assessment in place highlighting the risk of social isolation. The risk assessment recorded that staff should check on the person one to two hourly day and night. However their daily records showed the periods between visits by staff were longer than this, sometimes three to four hourly.

The failure to assess, review and monitor risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Many people were not able to express their views of the service verbally, however, those that could told us they felt safe. Relatives also felt their loved ones received safe care. The relatives we spoke with said, "I now can sleep at night knowing my [relative] is safe"; "Our relative is visited by a family member every day and we have never experienced anything untoward" and "Now I can feel confident that [my relative] is in safe hands at this home".

Staff had a good understanding of their responsibility to protect people from abuse. The guidance and advice staff would refer to about abuse if they had a concern to report was available through a safeguarding procedure. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us they would have no problem raising any worries they had with the provider or registered manager and they were aware of who to contact outside of the organisation should this be necessary. One staff member said, "We would be listened to here, without a doubt".

People continued to receive their medicines as prescribed from registered nurses. Medicines were kept safe and secure at all times within a locked medicine room. Systems were in place for the ordering, obtaining and returning of people's medicines. The medicines room and fridge temperatures were monitored and recorded each day. We checked the medicines fridge temperature, the thermometer showed a temperature of 15.9°c which was very high. Previous readings were recorded at between 4°c and 7°c which was within the recommended range. The registered manager and senior nurse took immediate action, transferring the medicines to a temporary fridge arrangement and contacting the supplier to provide a new fridge as a matter of urgency.

Robust recruitment processes were carried out. The provider had ensured that the appropriate checks were made to ensure only suitable staff were employed to support people living at the service. Applicants completed an application form and were asked to provide a full employment history. Interviews were held to assess their suitability and aid the decision making process. References were followed up and checks had been made against the Disclosure and Barring Service (DBS). This highlighted any issues there may be about staff having criminal convictions or if they were barred from working people who needed safeguarding. Nurses were registered with the Nursing and Midwifery Council and the provider had made checks on their PIN numbers to confirm their registration status

All the relevant maintenance and regular servicing checks were carried out by appropriate contractors and all were up to date. For example, gas safety, electrical installation safety, portable electrical appliances safety and legionella testing. All fire records were complete, those carried out by contracted engineers and weekly or monthly testing carried out by staff. Personal emergency evacuation plans (PEEP's) were in place for each person. A PEEP sets out the specific physical, communication and equipment requirements that each person had to ensure that they could be safely evacuated from the service in the event of a fire. One health and social care professional told us, "The environment has improved".

Infection control audits were carried out to ensure staff practices minimised the spread of any infection. Staff undertook training in infection control. Cleaning staff were given specific tasks to carry out each day to make sure the service was clean. The domestic staff knew people well and chatted as they were working. The home was free from unpleasant odours. A relative told us, "The Home is always clean and fresh and we find the staff friendly and helpful". Staff were seen to be wearing personal protective equipment such as aprons and gloves when going about their work. This helped to minimise the spread of infection in the service.

Requires Improvement

Is the service effective?

Our findings

The food looked appetising and people received good sized portions. People were happy with the food and the choices available. People told us they enjoyed the food and one person said they really enjoyed the meal they had just eaten. We could see this was the case as they had a second serving. Another person said, "Yes, I enjoy my dinner". Relatives confirmed that the food always looked appetising and their family member enjoyed the food.

Lunchtime was well organised to make sure people received their food at the right temperature and whilst it was fresh. The cook led the serving at mealtimes, giving staff the correct food choice and/or diet for each person. People ate at a lap table by their chair in the lounge or in their bedrooms. There were only two dining tables available with four chairs each in a smaller lounge but no-one ate at these. We asked why and were told this was people's choice, however, this was not recorded in their care plans. This meant that people were not given the opportunity for their mealtimes to be a social time where they could sit with each other and chat or have a change from sitting in the lounge or bedroom all day.

We recommend the provider and registered manager look at ways to create opportunities for people to choose different options for their dining experiences.

The Mental Capacity Act 2005 (MCA 2005) 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. Some mental capacity assessments had been undertaken with people who may lack the capacity to make decisions. The assessments in place were appropriate and related to a particular decision that needed to be made. Where it had been assessed a person lacked capacity, decisions relating to those assessments had been made in the person's best interests and had included the relevant people as necessary to make an informed decision. For example, one person had been assessed as not having the capacity to be able to consent to the personal care they required. A record of discussions held with their granddaughter who was next of kin and why it was agreed that it was in the person's best interests that staff made sure their personal care needs were met was documented. Another person was assessed as not having the capacity to understand bed rails needed to be used to keep them safe when in bed. A best interests decision had been made with the detail required to show how the decision had been reached.

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 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and nursing staff had carried out mental capacity assessments with people to determine if they were able to understand and retain the information necessary to consent to their care and support. Where people were found to have lacked the capacity to make this decision the registered manager had made the appropriate DoLS applications to the local supervising authority.

However, one person had a 'lap belt' on when sitting in their chair in the lounge to prevent them falling out of the chair. The belt kept moving up and was under their arms at one point. This was distressing the person as it was uncomfortable and they were wanting to take it off. When we checked their care plan there was no evidence of a mental capacity assessment being carried out to determine if the person had the capacity to consent to the lap belt being in place. No reference was made to the lap belt being used in their care plan. A lap belt constitutes a form of restraint if the correct processes are not followed to ensure a person's basic rights to consent to care and treatment are not upheld.

We recommend the provider and registered manager familiarise themselves with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure ongoing compliance with the principles of the Act.

People living in the service had complex health needs that required the knowledge and experience of registered nurses to make sure their needs were met. Referrals were made to health care professionals when necessary. A health and social care professional told us, "They do ask for assistance in a timely manner". A record was kept of visits made by health care professionals, such as a GP, community health nurses, speech and language therapists (SaLT) and dieticians. Family members were kept informed of any changes or concerns about a person's health. A relative told us, "We are always notified of any change in her health".

Staff received support through one to one supervision meetings with their line manager approximately every two months. Supervision meetings give staff the opportunity to receive feedback of their performance and to discuss support required to improve such as extra training. Staff can also raise issues that may affect their performance such as personal or domestic concerns. Staff confirmed they had regular one to one meetings. One member of staff said, "I am happy how things are, I have supervision at least every two months".

New staff received an induction to make sure they had the knowledge and confidence to carry out their new role before being signed off to work alone. A period of shadowing more experienced senior support staff members followed initial training. New staff continued to work in pairs with another member of staff until competent in their role.

Staff received suitable training to have the confidence and skills to undertake their role. Most training was through a range of DVD's to watch and learn, followed by a written assessment to test their knowledge. Completed assessments were sent away for independent marking. One of the senior nurses took responsibility for training. Although staff could go to any of the senior team if they did not understand part of their training, the responsible nurse was the focal point for this. The nurse also planned the training and made sure staff were up to date with their regular refresh updates. The moving and handling training was also provided by DVD. Some staff told us they thought this should be a practical based training course, although confirmed that new staff were shown how to use safe moving and handling techniques through their induction.

Nursing staff supported each other through the revalidation process with the Nursing and Midwifery Council (NMC). The NMC sets standards of education, training and performance so that nurses can deliver high quality healthcare.

Requires Improvement

Is the service caring?

Our findings

The emphasis of the care provided related to people's nursing and personal care needs. People's social and emotional well-being were not evidenced through records or what we saw during the inspection. Staff were caring and kind in their approach, however did not have the time to interact with people other than when providing for their basic personal care needs. This was a change to the previous inspection when staff were seen to spend more time chatting and carrying out activities with people. There was a more relaxed and happy atmosphere at the last inspection where staff were laughing and singing with people.

Daily records described the care given but rarely described the interaction staff had with people while delivering their personal care or throughout the day. Staff did not evidence that they had conversations with people and what they chatted about, the emphasis was on basic care giving. There was no evidence recorded that staff visited people in their bedrooms to chat, the records showed that staff went to people's rooms to deliver their care. Staff spent little time in the lounge areas, their attendance in the lounge was generally to carry out tasks such as assisting people with eating their meal. One person was asking for help in the lounge where 10 people were sitting. Another person shouted "Shut up". A member of staff looked around the door but did not come in to the lounge. The staff member then went off to do other things. The person started calling for help again 15 minutes later as they were worried about a belt they had in place around their body. No staff member came to assist so we went looking for help. Two staff went to the lounge at our request and although they were very caring and spoke respectfully in a kind way to the person, after they had adjusted the belt to make it more comfortable they left again to carry out their other tasks. The lounge was again devoid of staff. Within the period of one hour the examples above were the only contact by staff with people in the main lounge. Two staff were writing their care records in the smaller lounge where two people were sitting. They were sitting at a table at the other side of the room to where the two people were sitting and not taking the opportunity to converse with them while writing.

One person's religion had been recorded in the personal detail sheet as Roman Catholic, however, their care plan said they had no cultural requirements. There was no further detail regarding their religion and if in fact their religion had been important to them before they became unwell and assessed as lacking capacity to make some decisions. There was no evidence that thought had been given to the person's spiritual requirements and what their wishes may have been.

Some nurses called the people living in the service 'patients' even though this was their home and they were not actually patients.

Staff told us they would like to have more time to spend with people. One member of staff said, "That is something we could do better if we had more time. Everyone [staff] would want that". Another member of staff said, "We are all very caring. It would be better to have more time to do things with people".

People and their family members, although involved in their initial assessment were not involved in reviews of care plans following this.

The failure to provide care and support to meet the needs and preferences of people living in the service is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The bedrooms at the front of the building had large bay windows. There were no net curtains or window blinds up in these rooms so once the main curtains were opened there was a risk that people walking by could see in to the bedrooms. Two people shared a downstairs bedroom near the front door and close to a public path and road. Both people were nursed in bed and at times pushed their bedclothes off. Although curtains were in place around each bed to preserve people's privacy when receiving personal care, these were not always closed at other times. There was no record that people in these rooms had expressed this as a preference or what their choice of window coverings within their own living space were. This meant that people were at risk of being denied the preservation of their privacy and dignity.

The failure to ensure respect for people's privacy and dignity is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

In other respects people's privacy and dignity was respected, doors were closed when people were being given assistance with their care needs. Most bedroom doors were open through the day but staff knocked on the doors that were closed before entering.

Staff knew people well and could provide information about people when asked. When staff did get an opportunity to chat to people we saw caring exchanges. One person told us, "I am very happy here. I wouldn't like to live anywhere else now". Comments from health and social care professionals included, "Staff are always kind to the residents and willing to help" and "I feel the staff are very caring and compassionate about their residents".

Family members and friends were visiting throughout the day and were made to feel welcome. Staff obviously knew family members well as they were frequent visitors. Some relatives visited at mealtimes so they could help their loved one to eat their meal. We received compliments about the service from relatives. One family member commented, "We looked at several homes for my mother and chose this one because we felt it was family orientated".

Requires Improvement

Is the service responsive?

Our findings

People did not always receive person centred care that focused on their interests and well-being by providing individual support and meaningful activity.

People had the opportunity to take part in motivational activities twice a week organised by an external activities provider for one hour each session. Only the people who were sitting in the lounge were able to take part. An activities coordinator employed by the provider was responsible for providing activities twice, and occasionally three times a week for one and a half to two hours each of those days. The provider and registered manager told us the activities coordinator encouraged group activities in the lounge and also visited people in their bedrooms following this. We found little evidence that this was the case. An 'Activities folder' with an activity record sheet for each person was completed sporadically by the activities coordinator or staff. People who usually sat in the lounge had more records of activities than those who stayed in their rooms; however this was still not regular or often. The group activities in the lounge consisted of hoopler, bean bag toss or chatting. The activity sheet of one person who stayed in their bedroom showed records made on 13 May 2016, 18 April 2016 and 07 August 2017. Another person's activities sheet showed records made on 07 April 2017 and 04 August 2017. All the records we looked at had similar records made of engagement with people. Some activity recording sheets were for people no longer living in the service. We spoke to the registered manager about the activities folder. They told us they had not looked at the sheets in the activities folder as they left it to the part time activities coordinator. They agreed there were poor records of interaction and lack of meaningful activity for people.

We were also told by the registered manager that staff were responsible for ensuring people had meaningful activities at other times. We did not see any evidence of this recorded either. One person's care plan said they had liked gardening and knitting so staff should look at magazines with the person. There was no record that this had happened. One person was visually impaired. We asked the registered manager if there were any special provisions such as Braille books or talking books and we were told they would not be interested in anything like that. There was no evidence this had been discussed with the person.

The inspection day was warm and sunny. People were not asked if they wished to go in the garden or to a large park very nearby. There was no record of people going outside. We asked staff if people were supported to go out into the garden, all the staff we spoke with said people did not sit out in the garden, they only tended to go out when family members took them. A relative commented, "We just wish they had more opportunity to go into the garden when the weather is nice. The fresh air would do them good". One member of staff said, "It would be good if they went in the garden".

During the inspection a member of the domestic staff helped people in one of the two lounges to choose music and played the songs that they clearly enjoyed. This staff member went out of their way to spend time and keep checking on two people on their own in one lounge area. One relative told us, "The best people who communicate with my [relative] are the domestic and catering staff".

People were sitting in the lounges for long periods of time with staff only popping in occasionally when they

had the time. As there were few activities in place, people were reliant on the television or music playing but little social interaction with staff or between themselves. When staff found the time to chat with people, they clearly knew people and engaged well with them. However this happened on few occasions throughout the day. One staff member put a film on the TV, gave magazines to some people and chatted to one person in the afternoon at 16.30. This was the first observation of social interaction by staff on the first day of inspection. One member of staff said, "We could improve on activities, that's what could be better".

There were many relevant care plans to address people's nursing and personal care needs. For example care plans included; mouth care, foot care, tissue viability or skin care, personal care and communication. The care plans included the information needed to be able to meet people's basic care needs, concentrating on physical and medical care. However, care plans did not follow a person centred approach, taking a holistic view of the person to ensure their mental health and well-being were considered as an important part of their care.

Two care files were in use. One file was used by the nurses which contained all the individual care plans and risk assessments. The care file used by care staff was coloured yellow or green, with basic information for the use of care staff. This meant that staff may not have the information they required to be able to support people effectively and to understand why they were asked to record specific information. We asked the registered manager about the two separate care files. They said that care staff were "encouraged" to read the care plan file. However, they could not tell us how they knew if the care staff had indeed read the care plans and risk assessments as this was not followed up. We asked care staff about the two care files. The comments we received included, "One file is the nurses file and the other is for carers. I read the care plans when I have time", "I only work with the yellow and green folders. I don't look at the nurses' folder". One member of staff said, "I work with the yellow and green folders. We are told to read the care plans". When asked if they did read the care plans they said, "No not really as we don't have time".

The care file that was used by the care staff included daily record sheets, a personal history, a moving and handling assessment, an oral care assessment and an activities record. Some of these records were not kept up to date. One person's personal history was mainly blank, only current information was recorded such as name, date of birth and next of kin. Oral care plans showed that people who required support with their oral health should receive daily care. Oral care charts used to record the care when given, to provide consistency and maintain good care, were not completed consistently. None had been recorded in every day and most charts had only been recorded once a week. One person's oral care chart showed that the person had refused oral care for four weeks in a row, however, no comments had been made and there was no evidence that this had been reported to one of the nurses or the registered manager. Another person's oral care chart showed they often refused mouth care and stated on 15 May 2017, 'Sore mouth with thrush'. No further record had been made on the chart since then. The review of the oral care plan in May 2017 stated the person had commenced an antifungal medicine. The health care professional visit record showed a GP had visited at that time and prescribed the medicine. Their care plan or risk assessment had not been updated to reflect the change in circumstances or whether a change in approach needed to be considered. One health and social care professional said, "I do feel the paperwork [Care Plans] in the home are very poor".

Many people were nursed in bed and although their care plans stated they were nursed in bed, most did not give a reason why. Although some people were too unwell to be moved out of bed and some people had chosen to stay in their room, this was not evidenced in any of the care plans we looked at. There was no clear guidance for staff to encourage people to sit out in a chair or go to the lounge for a period of time. A health and social care professional said, "I would like to see more residents moved from their rooms and into the communal lounges where they can be seen more easily".

The failure to provide care and support to meet all the needs of people living in the service is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

An initial assessment was carried out with people, with the support of their relatives, in order to establish if the nurses and staff had the skills and experience required to care for the person and to meet their needs.

Resident and relatives meetings were held once a year. None had taken place since our last inspection, however, the next meeting was due to take place.

A complaints procedure was in place with the information required to enable people or visitors to make a complaint if they needed to. The provider had not included the details of the Local Government Ombudsman (LGO) if they were not happy with the way their complaint had been handled. The provider said this was an oversight and would correct it straight away. No formal complaints had been received since the last inspection. However informal, or verbal complaints had been received. These were mainly from people's relatives who raised issues with the provider. All the informal complaints were recorded in detail with the action taken and if the relative was happy with the resolution agreed.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 12 and 13 April 2016 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to; Regulation 17, Good governance. The provider had failed to ensure adequate auditing and monitoring were in place to check the safety and quality of the service provided; Regulation 18 Care Quality Commission (Registration) Regulations 2009, Notification of other incidents. The provider had failed to make formal notifications to CQC when a Deprivation of Liberty Safeguards application had been authorised by the local authority. We asked the provider to take action to meet Regulations 17 and 18.

Following the inspection the provider sent us an action plan on 08 July 2016 stating they had already taken action to improve the service and now met the Regulations. At this inspection we found that the provider had made improvements to their responsibilities in notifying CQC of important events and had sent notifications to CQC promptly and when necessary since the last inspection. Some improvements had been made to the quality monitoring systems. However, further improvement was required. We also found further concerns around record keeping.

A relative said their loved one had improved considerably after being at the home for a number of weeks. They said, "The owner is lovely, always listens and will do anything. She has put a lot into this home and is in fact "the home". Another relative told us they didn't see much of the manager but said, "[The owner] is lovely. She worries about the residents and their families just like a mother does".

The provider and registered manager had a range of audits they carried out and they were now completed regularly, every month. The audits undertaken included; cleaning and environment; medicines; health and safety; infection control; kitchen and catering and care plans. Completed audits were detailed and action plans were in place identifying improvements required. However, action plans did not name the person responsible for carrying out the action or a date that actions needed to be completed by. There was no evidence of follow up to check that action had been taken to make the improvements necessary. Some audits were not detailed enough to ensure a consistent approach. For example, the care plan audit did not list the areas that required checking. This meant that the senior staff completing the audits each month may miss important sections and therefore the opportunity for improvement could be missed.

Care plan audits, although being completed, did not pick up the areas of concern we found around the lack of person centred care, suitable deployment of staff, accidents and incidents, the timeliness of reviews of care plans and risk assessments, the lack of meaningful activities, the risks of social isolation, the shortfalls in gaining consent and poor record keeping.

Some daily recording charts were not completed consistently by staff. One person's bowel movements were monitored as they had a tendency to become constipated and may need medicine to prevent this. Their bowel chart had not been completed since 07 August 2017, a period of eight days. We looked through their daily records and staff had recorded that the person had in fact opened their bowels on some of the intervening days. We found another person's bowel recording chart that had also not been recorded on

between 05 August 2017 and 12 August 2017. This meant that the nurses may have administered medicines unnecessarily as important documents were not recorded consistently. Also people may have been left in undue discomfort through constipation with the potential for difficulties to arise. One person's tissue viability care plan stated to, 'apply barrier cream to sacrum every pad change'. However, the 'topical medicines' creams recording chart had not been completed since 23 July 2017, a period of 22 days. As record keeping was inconsistent, this meant that nurses would be unsure if people were having creams applied as prescribed or directed. People were at potential risk of the deterioration of their skin and associated issues.

One person was at risk of malnutrition and dehydration as they were reluctant to take food and drink at times. The person was admitted to the service suffering with malnutrition. This was clearly documented in their care file. A dietician had visited on 10 February 2017and left written advice in the person's care file which stated to, 'aim for 1500mls [of fluids] per day', 'offer two to three snacks between meals' and 'weekly weight and MUST'. MUST stands for Malnutrition Universal Screening Tool and is used to assess a person's nutritional risk. However, their food and fluid charts were poorly recorded. On 13 August 2017 only 380mls of fluid had been recorded for the whole day and on 14 August 2017 only 240mls of fluid. There was no record to evidence if staff had offered drinks and the person had refused. Although meals at lunchtime were recorded when eaten, tea time meals were often not recorded and no snacks were evident as having been offered, despite the advice of the dietician. Although the person was weighed, it was not always weekly and the MUST had not been completed since 07 July 2017. A review by a dietician on 31 May 2017 advised to increase supplement drinks to three times a day. This professional advice was not reflected in the care plan. The lack of consistent recorded evidence placed people at risk of not receiving the care and treatment they were assessed as requiring. We pointed out our concerns to the registered manager who had not identified these particular issues around poor record keeping themselves.

The provider had undertaken an annual survey to gain the views of other professionals involved in the service to gain their feedback. In June 2017 ten surveys were sent out and of these, eight professionals returned their completed survey. The results were varied, the comments made included, 'I haven't visited for some time but required redecoration last time. The care very good', 'Gaining entrance – have to wait long periods and phone answering' and 'Staff always friendly and welcoming. Would be nice to see more residents out of bed and engaging with each other and activities. Little activity appears to be provided and residents seem bored and under stimulated'.

A relative's survey was also undertaken in June 2017. Eleven relatives returned their completed survey. Among the comments received were two with similar points made to the comments made in the professional's survey. One relative commented, 'It would be nice to see the garden being used. I understand the level of staff needed but it would be nice to see people in the other lounge or outside' and 'Minor concern is waiting to enter (which requires a little patience)'. As these comments were similar to the concerns we found on inspection we asked the provider if they had taken any action to address these suggestions. The provider told us they had not taken any action yet.

The failure to ensure the systems in place to regularly assess and monitor the quality of the service were used effectively to take action to make the required improvements is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not received any one to one supervision meetings to discuss their performance and to provide support since December 2015. This meant the registered manager may not have the support required to provide effective management and leadership to the whole staff team.

We recommend the provider seeks to find a suitable source of effective supervision to support the role of the registered manager.

The registered manager had not held any staff meetings since 20 July 2016. This meant staff had not had the opportunity to get updates, receive peer support, share good practice, discuss poor practice or to make suggestions for improvement.

We recommend the registered manager seeks to develop an effective system of staff team support.

The staff we spoke with thought the service was well run. The comments we received included, "Overall I think it is well run. You can talk to any of the managers or nurses, even regarding personal things" and "The nurses and [the registered manager] and the owner are very good".

When asked if they had any concerns about the service, a health and social care professional said, "No but if I were I would have no problem taking my concerns to the manager of the home and would be confident that she would deal with the problem".

Staff told us team working was one of their strengths. One member of staff said, "We work well as a team, domestic staff, kitchen staff, nurses, all of us. We communicate well". Another said, "We are one big team, not individual staff or departments" and another staff member told us, "Good team working is what we are good at, we look out for each other".

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The registered manager and the provider had notified CQC about important events such as, Deprivation of Liberty Safeguards (DoLS) authorisations, deaths, serious injuries, events that affect the running of the service and safeguarding events that had occurred since the last inspection.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception area.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager failed to provide person centred care that met people's individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider and registered manager failed to maintain people's dignity, privacy and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to ensure individual risks were fully assessed, reviewed and monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to ensure staff were deployed in order to meet all the needs of people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to ensure the systems in place to regularly assess and monitor the quality of the service were used effectively.

The enforcement action we took:

We issued a warning notice to the provider and registered manager telling them they must make improvements to meet the regulation within a specified time period.