Scio Healthcare Limited

The Elms Nursing Home

Inspection report

Swains Road
Bembridge
Isle of Wight
PO35 5XS

Tel: 01983872248
Website: www.sciohealthcare.co.uk

Date of inspection visit:
21 May 2018
24 May 2018

Date of publication:
25 September 2018

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?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced inspection of The Elms Nursing Home on 21 and 24 May 2018.

The Elms Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Elms Nursing Home is registered to provide accommodation for up to 48 people. The home provides both personal and nursing care support to older people including those living with dementia. The home also provides short term rehabilitation support for people.

At the time of the inspection the home accommodated a total of 37 people. Accommodation was arranged over three floors with lift access to all floors. There were several communal areas and places for people to sit quietly and meet with their families or friends. There were accessible outside spaces for people to access. There were also small bungalows in the grounds where some people lived. However, we were told that the home does not provide any regulated activity to the people living in the bungalows so these were not considered as part of this inspection.

There was a registered manager who was present throughout the inspection. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This service was last inspected in November 2015 when we found that the provider had not ensured that there were detailed person-centred care plans for people. At this inspection we found that although some action had been taken to address this issue, additional improvements were required.

At this comprehensive inspection we found six breaches of regulations. Failures to provide safe care, person centred care, provide enough staff to meet people's needs, good governance and failing to act in accordance with the Mental Capacity Act 2005 were issues we identified during this inspection.

Quality assurance systems were not sufficient to monitor and review the quality of the service which was provided. These had not been used effectively to identify concerns we found or drive improvement in the service.

There were not enough staff to meet more than people's basic personal care needs. Staff were task orientated and did not always engage with people and support them to be involved in meaningful activities.

Care plans were not consistently person centred and contained conflicting information. Risk assessments

that related to people's health and safety did not ensure that all risks were effectively assessed. This exposed people to a risk of neglect and unsafe or inappropriate care or treatment.

Records of the assessment of people's ability to make some informed decisions had been undertaken. However, these had been recorded as generic decisions and were not decision specific. The principles of the Mental Capacity Act 2005 were not being applied in respect of best interest decisions to provide care or use least restrictive practices. This led to people being unlawfully deprived of their liberty.

Staff had received training to meet people's needs; however, this had failed to ensure that safeguarding processes were followed.

Peoples' wellbeing was not promoted due to a lack of person centred activities. We observed, and people told us, that activities were limited and did not take place as detailed in the schedule of activities.

People had mixed views about the food and choices were not offered in an effective way for people living with dementia.

We received some positive feedback about the staff and their approach with people using the service. However, some staff showed a lack of consideration for people's dignity, for example in the lack of communication when supporting people to eat or moving them to a different area.

People felt that the staff were helpful. However, several people told us that at times they had to wait a long time for support.

Most staff told us they were happy working at the home and felt supported in their roles by the registered manager. However, some felt that concerns they had were not listened to or not investigated thoroughly.

Staff had received regular supervision.

Staff completed pre-admission assessments before people moved to the home and people had access to healthcare services.

People and relatives told us they felt safe. The administration, safe management and security of medicines were in line with best practice.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Care Quality Commission (Registration) Regulations 2009. You can see at the end of this report the action we have asked to provider to take.

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.

Risk assessments were not always clear or consistent. Risk assessments that related to people's health and safety did not ensure that all risks were effectively and competently assessed. Action had not always been taken to ensure the safety of people.

Risk management included restrictions on people's ability to move freely and make choices.

Staffing was not planned effectively.

Staff knew how to report any concerns they may have in relation to people's safety. However, staff were not following the provider's or local procedures in relation to safeguarding concerns.

Medicines were managed safely and administered as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked the ability to make decisions, such as those relating to care, mental capacity assessments and best interest meetings or discussions had not been recorded for specific decisions.

The registered manager and staff were not always aware of their legal responsibilities in respect of depriving people of their liberty.

Staff received training to carry out their role. This had not always been effective in recognising where practices were poor.

People received a varied diet but meals were often given very close together and people were not always treated with dignity when being supported to eat.

Senior staff completed pre-admission assessments before

people moved to the home. People received effective healthcare and the service appropriately sought health advice and treatment in a timely manner.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always cared for and treated with dignity, respect, kindness and compassion.

People who were able to speak with us and their relatives were positive about the way staff treated them.

People were supported to maintain valued relationships with families and friends.

Confidential information was kept securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were always not supported to be actively involved in their lives and were not always provided with regular, meaningful and person-centred activities.

Care plans had been developed, but these contained inconsistent information and not been reviewed regularly with the involvement from people and their families.

Staff supported people at the end of their lives to have a comfortable, dignified and pain-free death and people's care plans contained information about their end of life wishes.

There was a complaints policy in place. People and relatives knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Governance arrangements were not effective in meeting fundamental standards of quality and safety or identifying the concerns we found.

Staff were happy working at the home, but there was a lack of

organisation in the way they worked.

People and their relatives felt the home was good and they could raise concerns with the registered manager.

The service worked in partnership with health colleagues to support people's health.

The Elms 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 21 and 24 May 2018 and was unannounced. On the first day of the inspection there was an inspector, an expert by experience in dementia care, and a specialist advisor in nursing care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day there were two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

During our visit we spoke with the registered manager, the area operational manager for the provider, one administrative staff member, two nurses, five staff, one ancillary staff member and a kitchen staff member. We spoke with thirteen people who were staying or living at the home, six relatives or friends of people and one external social care professional.

We looked at care plans and associated records for seven people and pathway tracked three people using the service. This is when we follow a person's experience through the service and allows us to capture information about a sample of people receiving care or treatment. We looked at staff duty rosters, feedback questionnaires from relatives, quality assurance records, records of compliments and complaints, accidents and incidents and the providers policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at The Elms Nursing Home. One person said, "The home is safe and comfortable with things done by the book." While another said, "Staff respond quite quickly if I'm unwell." However, during the inspection we found areas of concern that could impact upon people's safety.

During the inspection we found five separate safeguarding concerns, with four of these not being referred to the local authority safeguarding team or to CQC as required. Safeguarding is about protecting a person's right to live in safety, free from abuse and neglect. We discussed this with the registered manager who told us they were aware of four of the safeguarding concerns and told us that they had been internally investigated at the time. The registered manager had previously failed to recognise that one of the issues identified on the day of the inspection, was also a safeguarding concern, although they had been aware of the details of what was happening for that person. The registered manager could not assure us that thorough internal investigations that had taken place in relation to four of these safeguarding concerns. We reported these concerns to the local authority immediately. Although the provider took immediate action when these concerns were raised with them, we could not be assured that people were safe and that concerns were being fully investigating and acted upon in line with local procedure.

The provider had policies in place to protect people from abuse; staff had received training in safeguarding adults and they were able to identify different types of abuse and describe the actions they would take if they suspected or observed abuse. However, when staff had continued to have concerns about people's safety, they had not discussed this further with the registered manager or reported to the provider, local authority or CQC. Staff had not followed due process to ensure that people were protected from harm. We discussed these concerns with the provider following the inspection. They carried out full investigations into the concerns raised and arranged for the staff team to have additional training.

The failure to ensure people were protected from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the duty roster that showed how many staff were available to support people each day. Although it appeared that there were enough staff on each shift to meet people's needs, we saw that when staff members had finished their daily tasks they were sat away from people and were not easily available for people who were unable to use a call bell to request assistance. For example, we saw one person tried to get up and walk. Other people in the room alerted us that the person needed assistance to walk but there were no staff nearby to assist or prevent an accident. We looked for staff members and found that they were all in the handover meeting between the morning and afternoon shift. We had to alert them to the risk of the person falling. We observed two people who were in bed during the afternoon of the first day of the inspection. They did not have a call bell placed near them so they were not able to alert staff if they needed help. One person resorted to shouting out to get staff's attention and we observed them being distressed and in a state of undress. We had to go and find staff members to support the person and provide them with the assistance and reassurance they needed.

Staff expressed mixed views about the level of staff and people's safety within the service. A number of staff told us they thought people were safe, however other staff members said they did not feel there were sufficient staff to meet people's needs and ensure that people were cared for safely. One said, "I think we have enough staff now, but it depends, sometimes even with ten staff on, it isn't enough, it just depends." While another said, "We could do with more [staff], sometimes I feel very rushed." A third staff member said, "It's like a conveyor belt." We discussed the availability of staff to support people with the provider, who reviewed the way in which staff were working. The provider then arranged for additional training and support for the staff team, to address concerns about a task focussed culture.

The failure to ensure staffing was deployed effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments in their care plans which included the use of safety equipment to help people to move, risks about accessing the community and risks around eating and drinking. We looked at the care plans for seven people and staff had recorded that risk assessments had been regularly reviewed. However, we saw that information in risk assessments was not always consistent. One person's risk assessment for assisting them to move stated that they were able to walk with a frame, when another part of their care plan said they required the support of two staff and a hoist for all mobility. This meant that staff could place the person at risk when assisting them. We discussed this with the registered manager who told us it was an error in recording and asked a staff member to correct it immediately. Another person had a risk assessment which said they needed bed rails but in other parts of their care plan information was conflicting and said that bed rails were not to be used. This meant that risks had not always been recorded accurately and therefore information was inconsistent.

The provider had an accident and incident recording system. Processes were in place to monitor incidents and accidents and action was taken when needed, to reduce risks.

The provider had robust recruitment procedures in place, which included seeking previous employment references, obtaining appropriate identification and completing checks through the Disclosure and Barring Service (DBS) before staff commenced their employment. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have. We looked at three staff recruitment files, which all contained the relevant documentation. This meant that the provider could be assured that the people they employed were suitable to work with people who use care and support services.

The provider had policies around the use of medicines, including homely remedies, as and when required medicines (PRN) and covert medication. No one in the home was receiving covert medication at the time of our inspection. People's medicines were recorded, stored and administered safely. Fluid thickening powder was stored safely and staff were aware of the risks this can pose to people if ingested as a dry powder. Staff were aware of the people who required fluid thickening powder and there was clear guidance on what stage/consistency each person needed their drinks mixed to.

Medicines were administered by nursing staff who had received appropriate training and had their competency assessed by the registered manager. Systems were in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and disposal of unwanted medicines. This was supported by an audit system to check the medicine stock in the home and to ensure all medicines were accounted for. The times medicines were administered was recorded to ensure there was the correct amount of time between doses. One person required a specific medicine at a set time and this was consistently administered at the right time. Contained within medicines records for each person were descriptions of

how they liked to take their medicine and any particular needs. There was guidance in place to help staff know when to administer 'as required' (PRN) medicines, such as pain relief and medicines to help reduce people's anxiety. We saw that PRN medicines had been given to people and the reasons why this had been administered had been clearly recorded. Safe systems were in place for people who had been prescribed topical creams and these contained labels with opening and expiry dates. This meant staff were aware of the expiration date of the item when the cream would no longer be safe to use.

Environmental risks had been assessed and were monitored. Checks on the building and equipment in use, including bath hoists, sensor mats and call bells to alert staff if a person required support, were being carried out. Tests to check that the equipment was working were carried out weekly. This meant that people could be assured the equipment in use was safe. Gas and electrical appliances were serviced routinely and there were systems in place to check the temperature of all hot water outlets to prevent injuries or the outbreak of legionella.

There were policies and procedures for staff to follow in the event of an emergency and each person had a personal emergency evacuation plan (PEEP) which was available as a grab file in addition to copies which were in people's care plans. These detailed what assistance and evacuation procedures should be taken for that person in the event of needing to evacuate the building. Fire drills had taken place, which enabled staff to be clear about what to do in the event of a fire. Arrangements were in place to accommodate people at another home owned by the provider, should this be required in the event of an emergency evacuation. The provider's policy was that fire detection and management equipment would be tested weekly, and this was being done and different parts of the home were tested on a rotating basis.

The home was clean and was well maintained. The provider had a policy in place to prevent and control the spread of infection which included the reporting of infectious diseases. Staff understood the procedures required to reduce the risk of infection within the service. We observed staff using personal protective equipment (PPE), such as gloves and aprons when supporting people with personal care and PPE was available throughout the home. In addition, each person also had a drawer in their bedroom with stocks of gloves and aprons. Staff were encouraged to receive an annual flu vaccination offered by the provider.

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.

We looked at the care plans of five people that had been assessed to lack capacity for certain decisions. The care records contained best interest decision forms that were all the same, with the name of the person being the only thing changed. The form had the same single statement detailing how the person's nursing and care needs would be carried out in their best interest. The MCA Code of Practice requires that records are made in relation to specific decisions for people, how these decisions had been made and who had been consulted. During the care planning process, staff had made decisions on behalf of people. However, records in people's care plans showed decisions had not been made separately or for each person. For example, two people had been assessed as lacking capacity to consent to the use of bed rails but there were no decision specific assessments or records of the best interest decision showing that other less restrictive options had been considered or the reasons why they had been rejected. Another person had a mental capacity assessment around their ability to consent to taking medicines. Although the person had been assessed as lacking capacity to consent to this, no best interest decision was recorded.

We discussed this with the registered manager who had not recognised that the principles of the MCA had not been followed. This meant that the registered manager and provider had failed to ensure the legal requirements of the MCA had been met for people using the service.

The failure to meet the requirements of the Mental Capacity Act 2005 by recording decisions made in the best interests of people, who lack capacity, is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had not always applied for DoLS where needed.

On the second day of the inspection we saw that one person was being supported using restrictive practice. Restrictive practices are when people are prevented from doing something by a form of restraint, usually in order to keep them safe. The person was in bed at 2pm on the second day of the inspection when we went to see them. They were unable to move or walk without the use of mobility equipment and staff support. We saw that there were bed rails in place and there was no call bell for the person to request staff support and therefore they were unable to choose if they wished to remain in bed or not. The person was very awake and spoke to us when we went into their room and the curtains were drawn to darken the room. Although there

were no records in the person's care plan that explained why they should be in their bed in the afternoon, we saw that this had happened and when we spoke to staff they confirmed that they do this every day. There were also no records of a decision specific mental capacity assessment or a best interest decision in relation to this restriction. We discussed this with the registered manager who confirmed with us and an external social care professional, that they were aware of the person being put back into bed every afternoon and told us that they do this because the person is difficult to manage, makes a lot of noises and tries to get up from their chair. In addition, we discussed these concerns with the provider who took immediate action to address the restrictive practices being used, reviewed all people's care plans and provided training for the staff team.

The failure to ensure that lawful authority was obtained before people were deprived of their liberty for the purpose of receiving care or treatment is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were provided with training to enable them to carry out their role. However, this was not always effective as safeguarding training had not enabled staff to speak out when they had continuing concerns about people safety. More information about this can be found in the Safe section of this report. The registered provider used a training matrix to record and monitor when staff were due training updates. This showed staff were up to date with mandatory training such as fire safety, infection control and moving and handling training. Staff received annual refreshers and were also given the opportunity to sign up for additional courses in more specific areas such as dementia care. Training was mostly delivered by the providers internal trainer and staff were positive about the quality of their training. One staff member said, "Training is fantastic, [trainer] is lovely, they are a star."

People were provided with suitable and nutritious food and drink. We saw that the menu was changed each week and adapted to the different seasons. People were asked each day what they wanted to eat the following day. However, this was challenging for people who had dementia as they could not recall what they had ordered.

We saw that some people required their meals to be soft food or pureed and the kitchen staff accommodated this. They had detailed records of what food and drinks people liked, what their specific needs were and if they had any allergies. People had mixed views about the food. One person said, "I enjoy the food here." While another said, "The food is pretty average and not as good as home cooked meals, the food can be a bit overcooked." A third person said, "Food can sometimes arrive a bit cold and I have asked for it to be reheated at times." People who had lifestyle and religious choices about the food they ate were respected and their choices adhered to. For example, a vegetarian option was supplied if requested.

The environment was appropriate for the care of people living at the home although we saw one carpet on an upstairs landing that was very patterned and becoming threadbare in places. We discussed this with the registered manager and the area operational manager for the provider who told us that this was due to be replaced. We discussed the busy pattern on the carpet which can easily affect the perception of someone living with dementia and were told the new carpet would be a plain colour. All bedrooms were for single occupancy with ensuite facilities. In addition, the home had assisted bathrooms suitably equipped to support people with high care needs and located close to people's bedrooms. There were two communal lounges with additional sitting areas located around the home. There was one main dining room, with two smaller dining rooms on each floor where people could have a quieter environment or meet with their family and friends. The garden was accessible and suitable for those with limited mobility.

Technology was being used to alert staff to people's needs and care records were made on an electronic

system. All staff we spoke to were positive about the technology that they used for recording people's care needs. One staff member said, "It's made everything a lot easier now." Although staff felt that the technology for recording care needs was good, we saw that technology was not always used when it was required. For example, two people were left in bed unable to get themselves out unaided and had no call bell left within reach. This meant that staff were not always providing the technology available to people to enable them to receive support when they needed it. We discussed this with the registered manager who told us that people should always have a call bell next to them so that they can call for support.

Pre-assessments were carried out by the registered manager or senior nurse prior to people moving into The Elms Nursing Home. The registered manager told us that as part of their assessment they looked at the needs of the person to ensure the home could meet them. However, we saw one person's needs were more difficult to manage and staff were putting them to bed after lunch, as they did not have the skills or resources to meet their needs in other ways. Further information about this can be found in the Safe section of this report.

People's health needs were monitored, with staff using a range of tools such as for pressure injuries, nutritional needs and bowel movements. People were supported to access appropriate healthcare services when required and one person told us, "Staff respond very quickly if I am unwell." Their records showed that people were seen regularly by doctors and other health care professionals if needed and had access to chiropodists and opticians.

Nursing staff monitored people's health needs and we saw detailed records were kept, identifying when changes happened and when medical attention was needed. For example, one person required the care of a wound. Photographs of the wound were taken regularly to monitor and the GP had been alerted to changes that had resulted in further medical intervention being arranged. We spoke to nursing staff who told us that they made referrals when needed for needs such as speech and language assessments, opticians and mental health assessments. We saw records to evidence that people attended regular medical appointments and received visits from health and social care professionals, which were recorded in their care plan. For example, visit records showed contact from doctors, opticians and audiologists. Escorts were provided to support people to attend hospital appointments. This was so that the people could be supported to understand information about on-going health needs this information was clearly passed between the hospital and the home.

New staff told us they had received a thorough induction to their role when they started working and completed shadow shifts before they were able to work independently. Their induction included practical and classroom-based training covering relevant areas of their job role. Staff members were supported to gain up to date qualifications in care when they did not have them. For example, all care staff were supported to complete the Care Certificate or equivalent, which is a set of nationally recognised standards that health and social care staff must follow in their daily working role. Staff were also supported to complete higher level vocational qualifications if they wished to.

Staff were supported in their role through the use of regular supervisions. Supervisions and appraisals provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and consider learning opportunities to help them develop. Records showed that staff received regular supervisions and appraisals and staff told us they found these useful and valuable to their progression working within service. Care staff also said that they received regular unannounced observations by senior staff or nurses whilst they are delivering care and support to people. New staff received regular supervisions with management at one month and then at three month intervals to assess their progress and identify any areas of concern. One care staff member we spoke with told us that

following supervision where it had been identified that they wanted to progress to complete their nurse training, they had just been accepted onto a nursing course. The care staff told us that they were being supported by the provider, with the opportunities to complete nursing placements in the provider's other homes.

Staff were kept up to date about people's needs through handover meetings, which were held at the start of every shift. We joined staff for a handover meeting between the morning and afternoon shifts, which identified any particular needs that people needed support with and showed action was being taken to meet people's healthcare needs.

Requires Improvement

Is the service caring?

Our findings

People told us that they thought the staff were caring. One person said, "The staff do a very good job of looking after everyone and I am very happy." A relative told us, "The staff are all very friendly." We had mixed views from staff about if they enjoyed working at the home. One said, "There isn't time to sit with people to have quality time." While another said, "I like it here, it's a big family, everyone is helpful and we can call on each other."

Throughout the inspection we noticed that staff were task focussed and did not notice when people needed assistance. Staff did not have time to spend with people, talking to them or to engage them in what was going on around them. At times, staff seemed to be unaware of issues that could impact on people's experience in communal areas. We saw people with significant needs sitting for long periods of time with no staff support or interaction. However, on the second day of the inspection we saw staff sat with people in the main lounge playing a balloon game with them. Although records showed that activities and events were provided, daily interactions where staff could spend time talking with people or reading to them were not happening. People told us that they felt that there was not enough to do every day and staff were always busy. One person said, "This is a very good home with good care but does lack staff at times."

On the first day of the inspection we heard a person shouting out from their room, seemingly distressed. A staff member went into their room and despite the door being closed behind them, could be heard speaking to the person in an abrupt and loud manner, without offering reassurance. We also had a family member tell us that a staff member had shouted at them and this had upset them and their family member. We reported this to the local authority safeguarding team. However, we observed some staff speaking to people with kindness and taking time to explain what they were doing. One staff member was heard saying to a person, "Are you ready for your lunch, what would you like to drink?", while another said "[Person's name], are you alright in here [lounge] it's a bit crowded."

People's dignity was not always respected. Staff told us about how they ensured people's privacy and dignity when they completed personal care. For example, one staff member said, "I shut the door, close the curtains, cover them with a towel and let them know what I'm doing." Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. People's care plans contained guidance for staff on how to ensure people's dignity and privacy were maintained. For example, one person's care plan stated, 'Always cover me with a towel whilst washing, do not leave me exposed.' However, we saw on two occasions that one person was in their bed with the door open. They were pulling their bed clothes down and had no lower garments on. This meant that they were exposing themselves and due to their level of need, required staff support to maintain their dignity. On both occasions we had to find staff and ask them to come and help the person. Staff told us that the person often does this but no measures had been taken to consider how to resolve this so that the person's dignity could be better maintained. In addition, we heard staff referring to supporting people to eat their meals as 'feeds'. For example, one staff member said, "I've got to do two feeds." This further demonstrated a lack of respect for people and their vulnerability when they required a high level of support.

People's care and treatment was not always delivered in line with current legislation and standards to achieve effective outcomes and the care and support provided to people was not always effective. People had mixed views about the effectiveness of the service. While some felt they were well looked after, others felt staff did not have enough time to listen to them or help them when they needed it. One person said, "Staff are doing their best." While another told us that they felt happy that staff could deal with their everyday needs and support but sometimes had to wait for twenty minutes before staff were able to assist them. On the first day of the inspection one person, who had a diagnosis of dementia, was heard to be shouting out from their bedroom. When we entered their room, we saw that it was dark and there were used incontinence pads on the floor. They had no drink or a call bell to be able to alert staff to their needs. Later the same day, we again heard the same person shouting out from their room and saw that there was another used incontinence pad on the floor, the curtains were drawn and they had no call bell. This meant that people were not always receiving care and support that met their assessed needs and delivered positive outcomes.

We saw staff supporting people to eat their meals where they were unable to do so themselves. Staff were seen assisting people to eat without speaking to them at all. We saw one staff member support a person who was unable to verbally communicate. They gave no description of what the food was or that the next mouthful was about to be given to them. At the end of the meal the staff member wiped the person's mouth and walked away without saying anything to them. This demonstrated a lack of care for the person as an individual and treated them without respect or dignity. Another staff member was asked to support a person to move from the lounge area into the dining area. The person was seated in a specialist armchair that had wheels. The staff member went up to the person and quickly moved the chair with them in it, turning it and then going backwards. They did not speak to the person or explain what they were about to do so that the person would not become confused or fearful when they suddenly moved without warning. Conversely a senior staff member also moved someone in their chair but they carefully explained to the person what they were going to do, before slowly undertaking the manoeuvre. People with dementia can have significant difficulties with a sense of time and place and being supported to eat or to move without clear instructions meant that they were not receiving support in line with best practice. This could have had a detrimental effect on their wellbeing.

We discussed these concerns with the registered manager and the provider who took immediate action and arranged for training in dignity and respect for all staff. The provider also arranged additional training for staff which they told us would focus on care, comfort, companionship, person-centred care and how staff can involve residents in their life.

The failure to treat people with dignity and respect is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed some positive care during lunchtime. Some staff were speaking to people as they supported them and explaining what they were doing and describing the food, in line with best practice. One member of staff sat with a person and said, "Are you ready for your meal, we'll just put your hair out of your way, there that's better."

Care files contained information about people's lives and preferences. For example, people's care plans had information about their family, their past interests and who was important to them. Although some parts were written in a person-centred way and identified people's particular needs and preferences, other parts demonstrated task focussed and institutional language. For example, one person's care plan detailed the day they were scheduled to have a bath as, 'My bath day is Wednesday with team A'. This showed that the person's individual choices and needs were not assessed flexibly to provide care that met their needs and

that suited the individual person.

The home had an open door policy in respect of visiting and we saw a number of visitors to the home during the two days of the inspection. Family and friends told us that they thought the staff were caring. One family member said, "This is a warm and friendly home with good care." While another said, "This is a wonderful home." Families were invited to attend the special events that the home put on such as Easter and Christmas parties.

Staff met people's daily needs and people had clean clothing. Staff also spoke with us about how they encouraged people to be independent with personal care and one said, "I give them a flannel so they can do the bits they are able to themselves." People's rooms were personalised and they had their own toiletries in their rooms and were able to bring in their own furniture and belongings if they wished.

The service did not always ensure that people had access to the information they needed in a way that they could understand it. For example, people were supported to choose what they wanted to eat by staff. However, we did not see any use of pictorial menus to assist people in food choices and saw that people were given what staff told them they had ordered, if they could not remember the meal they had requested. The Accessible Information Standard (AIS), is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People living with dementia were not supported to understand information held about them in a format that considered any cognitive impairment. Therefore, the home was not fully compliant with the Accessible Information Standard. However, we saw that plans were in place to use a new electronic system using photographs/pictures of food to aid people with a cognitive impairment to make food choices.

Where people had spiritual or religious needs and preferences, these were known and met. Care plans detailed any spiritual needs people had and how these would be met. The registered manager told us that a local religious group visited once a month and conducted a Christian religious service. In addition, the home provided a Sunday morning service which was run by a staff member and local volunteers who come in to support people to join in. Although there was no one at the home with religious or cultural needs that were not Christian, we were told that these would be met should the need arise. The provider had a policy that recognised people's diversity and cultural needs and the registered manager told us that they would adapt the care and support provided to meet people's ethnic diversity and human rights.

The registered manager was aware of how to request the services of independent advocates if needed. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. They are independent people who spend time getting to know the people they are supporting to help make decisions that they believe the person would want. The registered manager told us that they had not needed to request an advocate for some time but had supported people to access advocacy services in the past.

Requires Improvement

Is the service responsive?

Our findings

Staff told us that they felt rushed when supporting people, and did not have enough time with people to deliver good quality care. When we asked staff if they felt people's needs were met by the service, one staff member told us, "Their basic needs yes, their wellbeing needs, not so much." Another said, "I really think they [people] should go out, I know there are some people here who would love to."

There were not enough staff to provide person centred care. On the first day of the inspection we observed people being sat for long periods with no interaction from staff. We spoke to people and their families and asked them if they felt there were enough staff to support them. One person said, "I sometimes have to wait 20 minutes to be attended to, they can be very short of staff, the little things seem to get forgotten." Another person told us, "The home could do with more staff as I can sit for around half an hour waiting for staff to help me with the toilet." On the first day of the inspection we observed that one person's call bell rang for ten minutes before staff answered it, however, when they did answer the staff member stopped the call bell then told the person they would be back soon.

Staff were not always deployed in a way that made them accessible to people. For example, two people who were in their bedrooms, did not have call bells within their reach and therefore could not request staff assistance easily. One person was living with dementia and another person was unable to independently move. This meant that people had to wait for extended periods of time for assistance.

Care plans contained person-centred information in some parts but in contrast also had task focussed language. These identified healthcare tasks and contained terminology that was institutionalised such as 'pad check' 'bath day' and 'feed'. However, each person's care plan contained a photo of the person, including those at the home for a short stay. Care plans contained detailed information about people's likes, dislikes and what they enjoyed doing. For example, one said, 'I like to watch sport on the TV and enjoy country and western and 60's music.' There was also a section dedicated to 'Food and nutrition', which contained specific information about people's preferences, such as, 'I like decaffeinated milky coffee with two sweeteners'.

The home used an electronic record system for people's care plans, risk assessments, and reviews. We saw that these were accessible to staff and staff were positive about the system. We found there was a lack of consistency in recording within people's care plans. In one person's care plan it described that staff should resuscitate the person if they stopped breathing. However, another section detailed medical visits and commented that there was a 'do not resuscitate or give cardio pulmonary resuscitation (DNACPR) form, in place. Another person's care plan stated that they had a 'normal' diet, whilst another section of the care plan stated they should have 'no sugar' due to their medical needs. This meant that people could receive the wrong treatment and support and this could put their health at risk.

Although relatives felt they were involved in people's care and support, they did not know when the home held a review of their relative's health needs or requirements. Care plans should be reviewed regularly and involve the person, their family or an advocate. We saw that monthly reviews of people's care plans were

undertaken by staff. However, these did not consistently involve people, their families or any advocates. The reviews had also not ensured that information in people's care plans was person centred and consistent. We discussed the lack of regular involvement of people and their families in reviews with the registered manager. They told us that they had taken action to resolve this and reviews were being arranged with people and their families throughout the next few months.

The home had two part time activities co-ordinators. Although we saw a sheet detailing the activities available, we saw little person-centred interaction between staff and people. On the first day of the inspection there was no activities co-ordinator working. Staff or nurses did not provide support to people with activities in their absence and people were sat with nothing to do and minimal interaction from staff. We discussed the activities co-ordinator's role with the registered manager who told us that at the time of our inspection they were both off work. We asked why other staff were not providing this support for people when the activities workers were not available and the registered manager acknowledged that this should be happening. However, we observed staff sat away from people when they had finished their tasks and they did not go and spend time talking to people. On the second day of the inspection we saw staff play a balloon game with people. However, people were not supported to be involved in social activities relevant to their individual preferences. We spoke to people and their families about activities in the home. All the people we spoke to told us that activities are infrequent and there is little to do. One person said, "There are a lack of activities for me to get involved in." Another said, "I could be much happier if I did not spend so much time sitting around doing nothing all day." A third person said, "There is no activity or entertainment in the home and it has been like this since I moved into the home, I would like a trip out to the pub." This meant we could not be assured that activities had been happening regularly or were person centred.

We were informed that at the time of our inspection there were no people receiving end of life care. Staff had received end of life training to assist them to support people at the end of their life and to make plans for any arrangements they would want. Records showed that end of life care had been discussed with people and their families and their wishes were recorded in their care plan. The registered manager told us that should people require end of life care, their care plans would be reviewed so that needs could be met comfortably with any pain relief required put in place in liaison with the local health centre and GP service.

People had visitors and the registered manager told us that they had links with the local community including a local nursery school who came into the home once a fortnight to spend time with people and a dog who came to sit with people. People were supported to celebrate their birthdays, invite family and friends in and the kitchen staff make a cake. The home recently held a special day for a royal wedding. We were told that they provided buffet food that people liked and they also had soft or pureed versions of the buffet food for those who required it. The home had been decorated and they made sure that all those who wanted to, were able to watch the event on televisions around the home. The registered manager told us that the home is known in the community for the events it puts on, which are held regularly throughout the year. These included garden parties and coffee mornings.

People knew how to make a complaint. We saw evidence where people had complained about minor issues. These complaints had been logged and responded to in line with the organisation's policy. There was a duty of candour policy which identified that when errors had been made, people would receive a full explanation and an apology if required. Following complaints made, the registered manager had spoken to people and their families and resolved the issues satisfactorily. We saw the home also had thank you cards which had been received from people thanking staff for the care they had received during a short stay or from relatives of people who had been receiving end of life care at the home.

The registered manager told us that relatives of people could use the technology available to log onto their

relative's records with their own unique log in number. This was so that they could see what their relative had been doing and how they were. They told us that access was only given to relatives where the person had given permission for their relative to access personal records.

Requires Improvement

Is the service well-led?

Our findings

People told us they felt the home was well led. One person said, "The home is well run, I have no complaints, this is an excellent place for me." Another person said, "The home is well run and I know who to speak to if I have any problems or concerns about the support that is being given."

There was a registered manager in place who was responsible for the day-to-day running of the service. Staff had mixed views about the running of the service and the support they received. One said "They [registered manager] are really supportive and open, they're really nice." While another said, "They always have an open door, so you can go in and talk to them, even if it's about something outside of work; they'll know if something is wrong, and pick up on it." However, another staff member said, "[Registered manager] is lovely and supportive, but they need to up their game. Things get swept under the carpet, they need to do something." A fourth staff member said, "Sometimes we aren't listened to, so how can the residents feel?"

In January 2018 there were some changes within the senior management of the provider's company. The provider Scio Healthcare Limited had not changed however, another company Hartford Care purchased Scio Healthcare Limited, meaning all directors and the nominated individual had changed.

During the inspection it was clear that on a number of occasions the registered manager had failed to meet the responsibilities associated with their role; for example, ensuring the principles of the Mental Capacity Act 2005 were being adhered to. The provider had an internal trainer delivering mental capacity training however, the registered manager and staff team had failed to recognise the poor practice of putting someone in bed to manage their needs and therefore unlawfully restricting their liberty. Although we were told that the area operational manager for the provider had weekly oversight of the home and spoke to the registered manager regularly, they had not identified the concerns we found during the inspection.

On the second day of the inspection an external social care professional was present at the home, to consider a safeguarding concern. When looking through the person's care plan the external social care professional asked if there was a risk assessment in relation to the bed rails that the person had in place. The registered manager told them that there was. Shortly afterwards, the registered manager produced the risk assessment. The external professional noticed that the date on the risk assessment was 'today's date'. They asked the registered manager if they had just completed the risk assessment in the office after being asked for it. The registered manager admitted that they had.

Quality assurance systems in place were not always effective. Although the provider had systems to audit the home, the standards of care provided and risks to people, these had failed to identify the concerns we found. Care plans were reviewed each month by staff but had failed to identify the inconsistencies meaning conflicting information was within care plans and put people at risk of harm. The principles of The Mental Capacity Act 2005 (MCA) were not being followed and this had resulted in people being unlawfully restricted. Records for mental capacity assessments were poor with single capacity assessments to cover all areas, instead of question specific assessments as required. Best interest decisions had not been made for people when needed, with records showing one single statement to cover all decisions made for that person. This

showed a lack of understanding of the principles of the MCA and a disregard for people's rights.

The failure to provide good governance to ensure the safety and quality of service provision is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we discussed these concerns with the provider who took immediate action to review all the systems and practices within the home. As a result, new equipment was purchased for one person to enhance their wellbeing and reduce the restrictions that had been placed on them. In addition, training had been arranged for the whole staff team to improve person centred care, dignity and respect for people living in the home.

Providers are required to inform CQC about various incidents and events which occur within the home. These are called notifications. We found one occasion of an accident which had resulted in a significant impact on a person, had not been reported to CQC as required. This had also not been reported to the local authority. In addition, we found that three safeguarding concerns had not been reported to CQC or the local authority. We discussed the failure to notify the CQC of these events and the registered manager recognised that this should have happened.

The failure to notify CQC of incidents which occur whilst services are being provided was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 (Part 4).

The provider had a whistle-blowing policy, which provided details of how staff could raise concerns if they felt unable to raise them internally. The staff were aware of the different external organisations they could contact if they felt their concerns would not be listened to. However, staff had failed to use this system to tell people outside of the service about on-going concerns that they made us aware of during the inspection.

The registered manager arranged regular staff meetings and staff told us if they were not able to attend, minutes were available, or a senior member of staff would relay what had been discussed later. We saw records that showed that the nursing staff met every month. Other staff also had regular meetings throughout the year. Staff told us they felt everyone worked together well and there was sense of teamwork within the service.

Providers are required to act in an open and transparent way when people come to harm. This includes a requirement to provide information, including an apology, in writing to the person or their representative. We saw that the provider had a duty of candour policy and the registered manager told us that letters would be sent out to people if this was needed following an incident or complaint. Following the inspection, the provider told us that duty of candour letters would be sent to all people required as a result of the concerns found during this inspection.

The provider had detailed policies and procedures in place, which were produced and updated by the provider's team. Policies were kept in an office that was accessible to staff.

Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection, undertaken in November 2015, was prominently displayed in the home and there was a link to the CQC's rating on the provider's website.

The provider had recorded the vision and values for the home and this showed plans that were being made to develop the service and improve the wellbeing for people living there. This included a full refurbishment programme which would consider how to make areas of the home more accessible to people whilst being

mindful of people's safety. However, concerns found during this inspection showed that positive values were not embedded in the practice of the registered manager and staff. All staff required support and training to ensure that people living in the home have an increased say in what is happening and are treated with dignity and respect at all times.

The registered manager told us that they had links with other providers, the local authority and other stakeholders. They were booked to attend a training course offered by another provider who had been rated as Outstanding. This is a management training course and looks at increasing people's involvement in their own lives and making choices amongst other things. The home also has a contact with the NHS to provide community rehabilitation beds. The registered manager told us they worked closely with their external health colleagues such as rehabilitation nurses, physiotherapists and occupational therapists who all come into the home to provide a service to people who received their care in bed.

The registered manager told us that they had regular contact with the provider's senior management team who provided internal and external updates, and also linked in with the provider's other registered managers.

The provider had a business continuity plan. The plan contained clear detail regarding the action to be taken in the event of specific incidents, such as a power supply outage. Information was clear for emergency contact information, guidance on prioritising risks and support from other local homes in the event of an incident.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Commission about statutorily notifiable incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to meet the requirements of the Mental Capacity Act 2005 by assessing people's capacity and recording decisions made in their best interest.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that people were safeguarded from abuse and that lawful authority was obtained before people were deprived of their liberty for the purpose of receiving care or treatment.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to provide good governance to ensure the safety and quality of service provision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff were suitably deployed to meet people's needs.