Lunan House Limited

# Warmley House Care Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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

About the service: Warmley Nursing Home is registered to provide personal and nursing care for up to 58 people. Some people may have a diagnosis of dementia. At the time of the inspection there were 31 people living in the home. The home was divided into three areas to support people with dementia, nursing needs and residential.

What life is like for people using this service: Throughout the inspection we received mixed views from people and relatives about the service. Care was described by one person as 'mediocre' and this reflected our findings. There was a sense of frustration from relatives because things had been slow to improve.

● Although there had been improvements in managing medicines since the last inspection, further improvements were required.
● Staffing levels were not adequate at the last inspection. We received mixed views about staffing levels at this inspection. Frustrations about staffing levels could not be judged on the numbers of staff alone. We had to consider other reasons why people and relatives might feel there were not enough staff. This included the lack of overall leadership, how each shift was led and the lack of cohesion amongst the whole staff team. We have asked that the provider continues to monitor this closely and to seek the views of everyone who uses the service as part of their ongoing quality monitoring.
● It was recommended that supervision for staff was reviewed, so that it was more meaningful and effective.
● Although improvements had been made to record and monitor fluid intake, there was a failure to ensure adequate nutrition that respected personal choices. The way in which people received their meals was not acceptable.
● The adaptation and design of the dementia unit required improvement.
● Although the home was clean, there was an unpleasant, stale odour in some bedrooms which needed to be addressed.
● People did not always receive care that was respectful or dignified. Person centred care and choice was not always promoted or supported. Care delivery had become task orientated at times particularly around personal care and at mealtimes.
● Complaints were not always managed well so that people felt they were listened to.
● Systems to monitor and audit the service was not effective and had not identified the improvements that were required.
● The service had not been consistently well led which had attributed to the failure to improve the service.
● The provider had continued to fail to identify or act to mitigate the risks to people of receiving care that was not consistently safe and of a high quality.

Rating at last inspection: Requires Improvement. (Report published January 2018).

Why we inspected: This was a planned inspection based on the rating at the last inspection. We saw small improvements had been made since our last inspection. However, we found further improvements were still

required and this meant the rating remained as Requires Improvement. This is the fourth consecutive time this service has been rated Requires Improvement.

Follow up: We will meet with the provider following this report being published to discuss how they will make changes to ensure the provider improves the rating of the service to at least Good. We will revisit the service in the future to check if improvements had been made.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

## 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

Details are in our Safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective.

Details are in our Safe findings below.

**Is the service caring?**

Requires Improvement

The service was not always caring.

Details are in our Safe findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive.

Details are in our Safe findings below.

**Is the service well-led?**

Requires Improvement

The service was not well led.

Details are in our Safe findings below.

# Warmley House Care Home

**Detailed findings**

## Background to this inspection

The 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 checked 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.

Inspection team:
On the first day of the inspection the team consisted of one lead inspector, a second inspector, a bank inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two inspectors conducted a second day at the service.

Service and service type:
Warmley House is a care home. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A manager had been in post since August 2018. They had applied with CQC to be the registered manager and this was being processed at the time of the inspection. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What we did:
Before the inspection we looked at information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events, which the service is required to send us by law. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make.

The service is being monitored and supported closely by various health and social care professionals following ongoing, continuous safeguarding concerns, previous inspections and breaches in our regulations.

We have referred to the intelligence reports we have received from those that visit the service and from the multi-agency meetings we have attended.

During our visit we spent a period observing how people were spending their time and the interactions between them and the staff team. We did this to assess what the quality of care was for those people who could not describe this for themselves. This was because some people had a degree of cognitive impairment or were living with dementia.

We spoke with 16 people living at Warmley House and seven relatives. We spent time with the managing director, area manager and manager. We spoke with 15 staff members including the administrator, registered nurses, care staff and ancillary staff.

We looked at nine people's care records, together with other records relating to their care and the running of the service. This included six staff employment records, policies and procedures, complaints, audits and quality assurance reports.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations had not been met.

We received mixed reviews from people and their relatives about whether the service was safe. Comments included, "Yes I feel safe here", "I am happy with the safety", "My relative is safe and well looked after", "I worry about my relative when I'm not here, I really do", "The worry is constant, but you have to put your trust in people", "I'm not sure about the night staff. I've been in a couple of times and they've just been sat down" and "I still worry about my relative to an extent but overall, I think she is safe. Her safety is regularly monitored by the nurses".

At the inspection of January 2018, we found people were at risk because of unsafe management of medicines. Following the inspection, the provider sent us an action plan about how they would rectify this and within what timescales. At this inspection we found these breaches had been met, however further new breaches were identified.

Using medicines safely

- There was no evidence that two pieces of equipment for administrating end of life medicines (syringe drivers) had been serviced. One of them had a sticker stating that the next service was due in February 2018.
- There was no evidence that the medicine refrigerators had been defrosted. The monthly defrosting records for one fridge for 2018 had not been completed since September 2018. There were no records for 2019 and the manager was not able to produce any records or explanation. The supplying pharmacy had completed an audit in December 2018 and this had been identified as an action point.
- Fridge temperatures were checked daily but those recorded in the residential unit were often at the maximum of 8 degrees centigrade. The supplying pharmacy had completed an audit in December 2018 and this had been identified as an action point.
- The manager or a registered nurse had conducted monthly medication audits. For those audits completed in March 2019, no actions had been identified. These audits had failed to identify the improvements required.
- Risk assessments were in place for the storage and safety of creams. These stated they should be stored in a closed unit and between 16-25 degrees centigrade. One person's creams were kept on the windowsill next to a very hot radiator.

The failure to ensure the safe management of medicines was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Senior care staff administered medicines to people in the residential unit. Training had been provided and regular competency checks were carried out.
- Medicines management was regularly discussed in staff meetings with the nurses and senior care staff.

● People received their medicines as prescribed. Where people needed their medicines administered covertly, the appropriate best interest decision documents had been completed.

Systems and processes to safeguard people from the risk of abuse

At the inspection of January 2018, risks to people were not always managed in a safe way. Care plans did not always provide enough guidance for staff on how to reduce these risks. Following the inspection, the provider sent us an action plan about how they would rectify this and within what timescales. At this inspection we found these breaches had been met.

Assessing risk, safety monitoring and management

● Care plans contained appropriate assessments of risk to people and provided instructions to staff on how to reduce the likelihood of harm to people they supported. For example, pressure ulcer prevention, reduction of falls and avoiding dehydration.

● We saw people being supported in line with their risk assessments, for example, being moved with the assistance of equipment or using cushions to protect their skin. Other adaptations were put in place to reduce the risk of falls which included low profiling beds and putting crash mats on the floor to prevent injury.

● Regular safety checks took place to help ensure the premises and equipment were safe. The records were detailed and complete.

● Personal Emergency Evacuation Plans (PEEPs) used by the emergency services to help people in the event of a fire were available in several areas of the home. Some care records contained more than one PEEP and the manager understood the need to just have one in records to avoid any confusion.

● On day one of the inspection, we noticed the fire exit on the lower ground floor was blocked by two trollies and a wheelchair. Immediate action to clear the exit was taken. On day two, the exit remained clear.

At the inspection of January 2018, the provider had not ensured there were sufficient numbers of staff to meet people's needs and keep them safe. Following the inspection, the provider sent us an action plan about how they would rectify this and within what timescales. At this inspection we found the breaches had been met. However, based on people's feedback it is strongly recommended that the provider continues to monitor this closely and to seek the views of everyone who uses the service as part of their ongoing quality monitoring.

Staffing and recruitment

● We received mixed views from people and relatives regarding staffing levels, on a few occasions it was clear that some views were historical. Comments from people included, "I think there are enough staff, they can be rushed especially if one goes down with illness", "The staff are always busy but I think there are enough staff in the main" and "In general I would say there are enough but sometimes if something urgent happens it can go wrong, and it seems less staffed at night". Comments from relatives included, "They could do with more staff. Today, they have plenty. Last time I visited and the time before there were not so many", "Staffing levels are terrible at times" and "No I don't think there are enough staff".

● Staff told us there were enough staff based on people's current needs. They said it was difficult when people went sick at short notice, but every effort was made to cover vacant shifts.

● The service had a system for calculating the number of staff required to meet people's dependency levels and the manager told us the service was usually overstaffed by one carer.

● The manager explained that staffing requirements were continually under review and that people's changing needs were considered daily. The manager's 'daily meeting' records evidenced that people's needs were considered by the manager, nurses and senior care staff.

● We observed how quickly call bells were answered during day one of the inspection. Apart from one occasion they were answered in a timely manner within two to four minutes. People and relatives told us, "They come quickly when I ring the buzzer", "The response time is variable. sometimes they all seem to be on a break at once. Staff could be better organised" and "It's not too bad, one would expect a little wait".
● The provider followed safe recruitment procedures.

Preventing and controlling infection
● The provider had infection prevention and control policies in place and staff had received training and had access to the equipment they needed to prevent and control infection including, disposable gloves, aprons, sluicing facilities, and cleaning materials.
● Ancillary staff worked hard to maintain a clean environment, although this was a challenge in some areas of the home where paintwork, soft furnishings, fixtures and fitting were tired and in need of updating.
● Every now and then there was a stale odour of urine, this tended to be found in bedrooms. When we tried to determine where the odour was coming from it appeared to be in the flooring, mattresses and chairs. The odours were old and it was questionable that any amount of deep cleaning would rectify this. We fed this back to the manager and area manager and recommended an audit of all bedrooms so that action could be taken. We will look at progress during our next inspection.

Learning lessons when things go wrong
● The manager, nurses and senior staff were responsible for recording when incidents/accidents had occurred in the home, the action they had taken and any learning from this.
● The service had an information system which detailed the frequency and times of when incidences occurred to help increase staff awareness of how to keep people safe. We saw examples where action had been taken to protect people, this included providing low profiling beds and 'crash mats' to help prevent injury if someone fell.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations have not been met.

At the inspection of January 2018, people were not being offered choices at mealtimes, and preferences were not being respected. In addition, we could not be satisfied that people were eating and drinking enough because their monitoring charts were not being completed. Following the inspection, the provider sent us an action plan about how they would rectify this and within what timescales. At this inspection we found these breaches had only been partially met.

Supporting people to eat and drink enough to maintain a balanced diet

● People's food choices were not always respected and we could not be satisfied they were receiving a nutritious diet. During the inspection one person told us they had been given the wrong breakfast. We saw their 'menu choice' records for three days including the day of the inspection. The person had not been given the meal they had chosen. We had to ask the care staff on two occasions to provide this person with the breakfast they had chosen.

● We knew from reading one person's records that they didn't like green vegetables. When we met with them at lunchtime their plate had broccoli on it which they had left. They had not been offered a choice of vegetables to accompany their meal. The meal had been served without asking the person if they wanted broccoli and staff were not aware of personal likes and dislikes. The person told us, "I've told them time and time again, I just give up now and let them serve it".

● People were negative about the quality of meals and the choices offered. Comments included, "I have asked them time and time again for soft boiled eggs but they are always hard", "The menus are out of the Ark", "You have to order for the next day but they make lots of mistakes. They tell us they have run out of certain foods or that it wasn't delivered" and "The food is acceptable but the choices don't attract me".

● Relatives told us, "The food is not brilliant. The choice and quality can be poor" and "Some people require a textured diet because they are at risk of choking. The puddings don't always lend themselves to a textured consistency and people end up with another mashed up banana".

● People's food must be placed within their reach and presented in a way that is easy to eat. Whilst we were walking around the home we saw a person who had been served their meal in their bedroom. The meal was placed out of reach on a table and the table was not set at the correct height. They had been given a spoon to eat with and the food had not been cut up. We readjusted the height and repositioned the table. We asked the person if they would like their clothes covered with a napkin and offered to cut up their food.

● We saw on three occasions that people did not have the appropriate equipment to effectively eat independently. These people were only able to use one hand to load their utensil with food. There was no plate guard in place and the food was falling off the plate onto the table, their lap and the floor.

The failure to ensure adequate nutrition that respected personal choices was a repeated breach of

Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Ensuring people received adequate fluids had improved and we saw on both days that drinks were in people's rooms and within reach. People told us they were provided with a hot drink at mid-morning, mid-afternoon and before bed in addition to mealtimes.
● The completion of fluid and food intake charts had improved since the last inspection and fluid intake was totalled at the end of each 24-hour period. This would help ensure that staff would be alerted to people where intake had been poor and any necessary action could be taken.

Staff support: induction, training, skills and experience
● Staff had attended additional training relating to the needs of the people using the service, for example, dementia awareness. There was a system in place to ensure staff training was regularly updated and monitored.
● Nursing staff were supported to complete specialist clinical training to ensure they provided safe care.
● Staff had received regular supervision. However, staff were not always given opportunities to discuss issues important to them. Supervision had not been tailored to individual need. One supervision record was focused on performance management whilst another contained very little detail, making it difficult for any meaningful follow up at the next session.

We recommend that the provider considers the process for supervision at Warmley House so that it is more effective and meaningful for staff.

Adapting service, design, decoration to meet people's needs
● Since our last inspection the provider had ceased using the accommodation on the top floor which had been for people living with dementia. This environment was inappropriate for people living with dementia and this was a positive step.
● Those people had been moved to another part of the home. This unit required adaptation and design so that it was suitable for its intended purpose.
● Some people on this unit like to spend time walking, often this was because they were anxious or restless. They were not able to do this in a meaningful way. They were only able to pace for short distances before they had to turn around and walk back the same way.
● Plans had been made for the dementia care framework team to start work on this unit in April.

At the inspection of January 2018, we found improvements were required because the provider had not ensured people were consenting to care in accordance with legislation and guidance. Improvements were required around systems in place for assessing people's capacity. Following the inspection, the provider sent us an action plan about how they would rectify this and within what timescales. At this inspection we found improvements had been made and the breach had been met.

Ensuring consent to care and treatment in line with law and guidance.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes this is usually through MCA application procedures called the Deprivation of Liberty Safeguards

(DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● People told us, "Consent, yes. They always tell my relative what they're doing", "They always ask me before they do things for me" and, "They ask my permission".
● Mental capacity assessments had been completed for people and decisions made in their best interests were recorded.
● Necessary DoLS applications had been submitted and conditions complied with.
● The service kept a record of all DoLS applications and ensured that people, their relatives and other health care professionals were involved in decisions about their care. We made the manager aware that one entry in a person's care record which said 'DoLs now put in place' had not happened, so the entry was misleading.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care.
● Care records showed staff worked with health professionals to ensure all aspects of people's care needs were met.
● Records and correspondence showed appropriate and timely referrals had been made to health professionals and advice provided had been acted upon.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments were completed for those who were considering moving into the home. The information supported the manager and prospective 'resident' to decide whether the service was suitable and their needs could be met.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations have not been met.

Respecting and promoting people's privacy, dignity and independence
● Staff we spoke with displayed kind, caring natures, but we saw some practices around dignity and respect that required improvement. When we reported on our findings, we asked the provider to consider the following as a possible cause; ineffective training and a lack of leadership within the home and on each shift.

● One toilet facility was used to store laundry skips. One person told us when they used this facility, staff would knock on the door and say they needed to enter the room with dirty laundry. This person felt the staff did not respect their privacy.
● Although some people were dressed in nice clothes and looked well cared for, we saw others who looked unkempt. Some men were unshaven, clothes were stained, some people didn't look as if their hair had been combed, nails were dirty and long. One gentleman was wearing trousers that were so short, they only reached mid-calf.
● Some of the poor practice we observed at mealtimes further evidenced a lack of dignity and respect.
● As mentioned in the safe section of this report, we saw good response times from staff when people called for support with their call bells. However, there was one occasion where it took ten minutes for staff to respond to one call bell. During these ten minutes we saw two members of staff leaving the unit, two staff remained seated in the lounge with people watching a film on television. Neither responded to the call bell until they saw us and demonstrated a lack of respect for the person who was asking for support.

Ensuring people are well treated and supported; Supporting people to express their views and be involved in making decisions about their care
● We received mixed views about the staff and care they received. Comments were dependent on people's and relative's personal experience. Staff had good intentions, and it was evident when speaking with them that they cared about people. However, it was evident that poor practice and habits had been picked up and a person-centred approach was not consistent across the whole home.
● People told us, "They are very good here, they do help me but I try and do what I can. That is important", "Certain staff are kind, others don't haven't the manners to be kind", "They don't always see the jobs to be done and they do as little as possible", "One girl in particular is very good. I try and make sure she deals with things for me" and "They do their best".
● Relatives told us, "I'm not satisfied with the care", "The nurses are very good, it's has not always been like that", "The care staff are good and kind and speak with my relative. I have some reservations about the night staff though. They are not so attentive" and "I can't fault the staff. They are lovely but under such pressure".
● There were things we observed and heard that had a negative impact on how people were treated and supported. When staff took people's plates away, they did not always ask if they had finished their meal and

if they had enough to eat. One person told us items of clothing had gone missing and they saw other people wearing them. People were not all offered a choice in what they wanted to drink. One staff member asked a person what they would like to drink with their meal and they requested orange juice. The member of staff went to get a jug of orange juice and then proceeded to give everyone else orange juice without asking them if this was their preferred choice.

The failure to promote dignity, respect and autonomy is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were not always met. Regulations have not been met.

At the inspection of January 2018, we found care plans were not person centred and did not always provide enough detail for staff on how to meet people's needs. Following the inspection, the provider sent us an action plan about how they would rectify this and within what timescales. At this inspection we found continued improvements were required.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

- Care plans in the nursing and dementia unit required further improvement. We saw plans had been re-written following the last inspection but they did not always reflect that people had been involved. They were written in a way that gave staff instruction rather than describing what the individual wanted or requested.
- Care plans had not been developed for people who had a diagnosis for conditions such as dementia, stroke or Parkinson's. These conditions were referred to in other care plans, for example mobility, personal care and nutrition. However, the information did not provide staff with enough information on how such conditions impact on people. In particular it did not relate to the psychological and emotional effects they would have on people and how to recognise these symptoms and support people effectively. These conditions also affect people in different ways and this should be reflected for people individually.
- Care provided had become task orientated where staff followed a daily routine. One person described care received as 'going through the motions'.
- We could not be satisfied that people received good personal care. People and relatives told us baths or showers were not offered very often. As previously mentioned in the report people looked unkempt. We read complaints from people and relatives about lack of shaving and showers. One relative stated when they visited, their relative's toothbrush was always dry after they had received personal care.
- There was no one receiving end of life care at the time of our inspection. Some people in the residential unit had started to consider their personal wishes when the time came. It was evident they had been supported and that effective discussions had taken place. Care plans in the nursing and dementia unit were either not completed, or contained basic details about when to call family and chosen funeral directors.
- The quality of the information recorded in daily notes was task orientated and provided little insight about how the person was feeling that day or how their emotional needs were met.

The failure to work in partnership with people so that there care and support was meaningful and individualised was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The care plans in the residential unit had made good progress and highlighted people's voice. For example, one person had been involved with developing a care plan to reflect how they wanted their night-

time experience to be. This was very detailed and even explained to staff how they preferred their bed to be made.

● There hadn't been any significant changes with regards to activities since the last inspection. It had been identified that additional training for the activities coordinators would further enhance people's experiences, particularly for those with dementia. In addition, they were going to contact and visit other homes within the local area who were known champions in this area. We look forward to seeing how this has had a positive impact for people at our next inspection.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy and procedure in place. These were not always followed correctly so that people and relatives would receive a satisfactory outcome. The records we were given did not demonstrate that people had always been listened to and what had been done to rectify complaints made.

● One relative told us, "I did make a complaint. A nurse told me off for speaking loudly to my relative. They didn't seem to understand I sometimes speak loudly because of my poor hearing. I complained to the manager but nothing has been done about it". We could not see any details logged about this complaint from the records we had been given.

● Another relative said, "I complained three weeks ago. It has been sorted but I would have liked the manager to come and speak to me personally about it".

The failures in consistent recording, handling and responding to complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations have not been met.

Continuous learning and improving care;
Since the inspection of January 2018, the provider had continued to fail to identify or act to mitigate the risks to people of receiving care that was not consistently safe and of a high quality. We could not be satisfied the service was well led due to repeated breaches and the new breaches we had found. This was the fourth consecutive inspection where the service required improvement.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- There was not a clear focus on continually seeking to improve the safety and quality of care that people received. There was not a positive culture that was person centred, inclusive and empowering.
- We received mixed views about the manager. Comments from people and relatives included, "You have to give the manager a chance", "Every time I've seen him, he's done things for me", "The manager is just about approachable", "Quite often he is not here", "I've not seen him around at night at all" and "I've not seen the manager".
- Staff told us, "I think the manager is doing his best", "He always asks me how I am", "Some things have improved but there is still lots to be done" and "It's difficult to improve a home when everyone is not on board".
- There had been a longstanding culture within the staff team that had been difficult to manage. There continued to be a theme of staff breaking off into groups, for example the nurses and care staff. This had a negative impact on staff working together as a cohesive team for the benefit of people in their care. The absence of a deputy manager had further impacted on any progression to change this culture.
- We asked people and relatives about the quality of care and would they recommend the home to others. Comments included, "I would give it five out of ten. There are too many ifs and buts and nothing gets done", "I would not recommend it here", "In the sense that I have seen far worse places then yes I would recommend it", "Yes, we are happy with the quality of care", "I would give them five out of ten, I feel I have to be here every day to make sure my relative is ok" and "I have recommended the home to a neighbour".

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had not considered the Key Lines of Enquiry (KLOE) which CQC inspect against and how they planned to improve. Systems to monitor and audit the service was not effective and had not identified the improvements that were required.
- We looked at records and found incidents that CQC had not been notified about. The manager did not always understand their responsibilities and duty of care to raise safeguarding concerns when they

suspected an incident or event that may constitute abuse.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Those people living with dementia were unclear about whether they were involved in discussions about their care. Care records in the residential unit evidenced consultation with people, however the records in the nursing and dementia unit did not. Two relatives told us that they were kept informed and up to date with any changes in their relative's care.

● The manager had arranged one relative's meeting held in January. One relative who attended the meeting told us, "I went to the meeting. I'm still waiting for the minutes to see if the points I made were recorded. The manager spoke too much about what he had been doing. He glossed over any questions or points that were made by us. I raised points about the number of staff on duty". We saw from the written notes of that meeting that a relative had asked about staff breaks and how these were monitored. Relatives had concerns that when staff went on breaks there were not enough staff remaining in the building. We saw in the typed minutes from the meeting that these comments had not been included and there was no indication that these comments had been considered.

● Although annual surveys were sent to people and relatives we could not be satisfied that they were listened to, based on the feedback received during our visits.

The failure to assess, monitor and drive improvement in the quality and safety of the services provided was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to notify CQC of incidents was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Working in partnership with others

● The provider and manager attended local provider and care home forums and Care and Support West meetings.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The service failed to notify CQC of incidents. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The service failed to work in partnership with people so that there care and support was meaningful and individualised. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>There was a failure to promote dignity, respect and autonomy |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>There was failure to ensure the safe management of medicines. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>There was a failure to ensure adequate nutrition that respected personal choices. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>There were failures in consistent recording, handling and responding to complaints. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The service failed to assess, monitor and drive improvement in the quality and safety of the services provided. |