Bupa Care Homes (CFHCare) Limited

# Wentworth Croft Residential and Nursing Home

## Inspection report

Bretton Gate
Peterborough
Cambridgeshire
PE3 9UZ

Date of inspection visit:
12 April 2016

Date of publication:
16 May 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This unannounced inspection was carried out on 12 April 2016.

Wentworth Croft Residential and Nursing Home provides accommodation for up to 156 mainly older people who require nursing and/or personal care. The service offers accommodation over one floor within four separate houses. Woolsack House provides personal care, Hayward House provides dementia care, Harvester House provides dementia care and nursing, and Yeoman House provides nursing care. Each House has single occupancy bedrooms with ensuite facilities and there are internal and external communal areas, including lounges, dining areas and gardens for people and their visitors to use. There were 87 people using the service at the time of our inspection.

At the time of our inspection there was no registered manager was in place. A manager was in place and they were intending to apply to become the registered manager. However, we were informed during the inspection that this person had resigned. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous inspection on 31 July 2015 we found that improvements had been made following our inspection on 30 October and 12 November 2014 where we had found breaches. These breaches were due to concerns identified about low staffing levels, ineffective quality monitoring systems and notifications of important events the provider is required to notify us about by law not being submitted. Following this inspection on 30 October and 12 November 2014 the service was rated overall as 'requires improvement'. At this inspection on 12 April 2016 we found that the improvements across the service evidenced in the July 2015 inspection, had not been sustained by the provider and that people were still placed at risk.

During this inspection we found that there were concerns in two out of the four houses. These were Yeoman House and Harvester House. This was because there were not enough staff to meet people's care and support needs in a timely manner. We could not be assured that people received appropriate care to meet their needs.

People's care and support plans were in place to give guidance to staff on any individual assistance a person required. Records included how people wished to be supported, and what was important to them. However, due to the lack of staff available in two of the houses, people were not receiving the support that they required. We found that not all of these records documented people's up-to-date care and support needs. Staff told us that they did not have time to read these records in full.

People's care records and reviews of these records documented that where reasonably practical, people or their appropriate relatives had been involved in this process.

People were not always protected against the risks associated with the unsafe management of their prescribed medicines. Robust processes were not in place to ensure that people received their medicines safely and as prescribed.

Robust safety checks were not always carried out on all new staff to ensure that they were deemed safe to work with people who lived in the service.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. Where people had been assessed as lacking capacity, decisions were made in their best interest. Applications had been made to the local authorising agencies to lawfully restrict people's liberty where appropriate. Not all staff had an embedded understanding of this legislation.

Staff understood their roles and responsibilities. Although records showed that staff received training, we found that staff were not able to support and care for people's individual needs in an effective way. Not all staff received regular supervision where they could discuss any issues they may have and where they could review and agree their skills and development needs.

People at risk of malnutrition were assessed by external health care professionals and we saw that this input and advice had been followed by staff. The choice of foods available to some people was limited. Records for people deemed to be at risk of malnutrition or poor skin integrity were not always completed in full or in enough detail for their intake to be monitored effectively.

There was a system in place to receive and manage complaints. However, the provider could not demonstrate whether a complaint had been resolved to the person's satisfaction.

Quality monitoring systems were in place, but there was a lack of provider and managerial oversight of the service and improvements had not been sustained.

People and their relatives had been asked to provide their feedback on the quality of the service so that the provider could see what was going well and what required improvement. Feedback showed that people wanted an improvement in the quality of care that they/their family member received.

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

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

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate in any of the five key questions it will no longer be in special measures.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

People's individual care and support needs were not always met in a safe and timely manner as there were insufficient staff.

Robust checks were not in place to recruit staff safely.

People's prescribed medicines were not managed safely.

### Is the service effective?

**Inadequate**

The service was not effective.

Staff were not always trained to meet the individual needs of people and staff competency was not monitored.

Staff did not receive appropriate supervision and appraisal for their role.

The majority of staff had a basic understanding of the MCA and DoLS to ensure that people were not having their freedom restricted in an unlawful manner.

People were not appropriately supported to maintain good hydration and nutrition and the choice of foods available to some people was limited.

Referrals were made to the appropriate external health care professionals for people when required.

### Is the service caring?

**Inadequate**

The service was not caring.

Due to the lack of staff on duty in two of the houses staff had insufficient time to spend positively interacting with people.

Staff encouraged people to make their own choices where possible about things that were important to them and help maintain their independence.

People's privacy and dignity were respected.

## Is the service responsive?

**Inadequate**

The service was not responsive.

Staff were not able to respond to people's needs in a timely manner.

Activities happened within the service, but people were not always supported by staff to take part or maintain their individual interests.

There was a system in place to receive and manage complaints. However, the provider could not demonstrate that complaints were resolved to the person's satisfaction.

## Is the service well-led?

**Inadequate**

The service was not well-led.

There had been no registered manager at the service since March 2015.

Systems were in place to monitor the quality of the service provided but these were ineffective.

There was a lack of managerial oversight of the service which meant that people did not receive a consistent service.

People who lived in the service and their relatives were asked for their opinions on the quality of the service provided.

# Wentworth Croft Residential and 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 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.

This inspection took place on 12 April 2016 and was unannounced. The inspection was completed by five inspectors and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service. Their area of expertise was older people and people living with dementia.

Before the inspection, we asked the provider to complete and return 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 any improvements they plan to make. The provider completed and returned the PIR form to us and we used this information as part of our inspection planning.

We looked at other information that we held about the service including information received and notifications. Notifications are information on important events that happen in the service that the provider is required to notify us about by law.

On the day of our visit, we observed how the staff interacted with people who lived in the service. This helped us understand the experience of people who could not talk with us.

We spoke with 19 people who lived at the service and nine of their relatives. We also spoke with the area manager; head of care; clinical services manager; three unit managers; a deputy unit manager; three nurses; three senior care staff; 12 care staff; chef manager, customer services and three activities co-ordinators. We received feedback about the quality of the service provided from a representative of Peterborough City

Council contracts monitoring team and a visiting GP. The provider had an action/sustainability plan in place for the service and we used this to inform part of our inspection planning.

As part of this inspection we looked at 10 people's care records and four staff records. We looked at other documentation such as quality monitoring information, complaints and compliments, staffing rotas, medication administration records, staff meeting minutes and feedback on the service.

Inadequate

# Is the service safe?

## Our findings

We found by our observations, and by speaking with people, their relatives, and staff, that there were not enough staff on duty on two out of the four houses. This meant that people living in Yeoman House and Harvester House did not receive a safe level of care.

We spoke with the area manager, clinical services manager and head of care about how safe staffing levels were determined. They showed us an organisational document called a 'staffing ladder' which determined the number of staff based on the number of people in each of the houses. However, this document did not factor in people's different needs; for example how many staff people needed to support them safely. We saw in the care records we looked at; that people were assessed and placed into a 'banding' which represented their dependency needs on their pre admission assessment when new to the service. These bandings were then fed to the local authority and formed a basis of the funding for the person. However, we found that people's needs had been incorrectly assessed or had not been updated since before they moved into the service. The clinical services manager told us that once the person's dependency needs banding had been established it was difficult to update and change. We asked the area manager to provide us with evidence that people's current dependency levels were used in conjunction with the staffing ladder to determine safe staffing numbers in each of the houses. This evidence was not produced.

The majority of staff spoken with in Yeoman House, which provides nursing care, told us of their concerns about low staffing levels and the impact this had on the people they supported. They confirmed to us that this was not an unusual day and one staff member said, "It is always like this." Of the 27 people living in Yeoman House, 26 people required support from two staff with their personal care and to help get out of bed. Staffing in this house on the day of inspection, was two agency nurses and six care staff. However, one carer was on sick leave and another staff member was supporting a person with a hospital visit so this left four care staff for a time. A member of staff was taken from another house [Woolsack] to help.

At 3pm in Yeoman House, we saw that there were still five people who required assistance from staff with their personal care. A staff member told us, "[There is] no point getting people up at 4pm, because we have to put them back to bed straight away. We are neglecting people and not providing the right care and have no time to talk to people." Another staff member said, "Staff are getting burnt out and going off sick," and, "[Management] is not listening to us when we say we are short staffed. I can't understand why they haven't acted on our concerns." Our observations showed that the last person supported by staff with their personal care on Yeoman House was at 4.30pm.

The lounge and dining area in Yeoman House was empty of people whilst breakfast was being served at 9.40am. We spoke to the clinical service manager about this. They confirmed to us that 20 out of 27 people living in the house required assistance from staff with their meals. They told us that, "Of the six carers on the list [to work the shift], one was not here and another had gone with someone to a hospital appointment." They confirmed that they were waiting for a member of staff from another house to come and help. A staff member told us, when asked why the lounge and dining area was empty of people that, "Sometimes people come to the dining room for breakfast – it depended on whether the night staff had been able to get anyone

up – last night they hadn't." A third staff member said, "Night staff don't get anyone up so everyone needs supporting when we arrive, some have a wash but are then put back to bed." Incident forms showed that in February 2016 staff were concerned about low staff levels within the house. On one occasion agency staff had been agreed as an action to resolve the situation. However, as the area manager was uncontactable, the agency staff member was not able to be authorised until part way through the shift.

On Harvester House, which provides nursing care for people living with dementia, a relative said, "I feel there could be more staff. Sometimes there are no staff in the lounge. Two or three times over the last year I have been here and people have fallen, [and] I have had to go and find a member of staff." They also told us, "My [family member] raised a complaint to the manager via an e-mail following their last visit to the service. This was because they could not find any staff in the lounge; they walked along the corridor to find a member of staff and heard a man calling out from their room for help. [Family member] described the smell as horrendous so they clearly needed assistance from staff, but [family member] observed a carer walk straight past his room." We spoke with the unit manager about this during our visit and they confirmed that this did happen and that this had been addressed with staff during 'hand over'. Staff confirmed their concerns that staffing levels did not meet people's complex health, care and support needs. The deputy unit manager said that alongside the unit manager, they spent most of their time providing direct care: administering medicine, assisting with people's personal care needs and supporting people with their meals. They confirmed to us that they were currently struggling with staffing levels and the high dependency needs of people. This meant that they were not able to manage their duties in their capacity as managers.

Our observations in Harvester House showed that staff had provided all people's personal care and got those who chose to do so, up from bed just prior to lunch which was served at 12.30pm. We saw that during lunchtime that there were not enough staff to support people with their meals. We saw that they had to sit and watch other people being supported. This meant that people had to sit and wait for staff to become available to assist them before they could have their meal.

Nurses spoken with confirmed to us that when they had only one staff member supporting people with their breakfast, they had identified a trend that people had lost weight. They said that two members of staff assisting people meant that they were able to monitor people's food intake better. This meant that people did not benefit from a service where there was enough staff to provide support that met their individual and complex needs.

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

Staff had been trained in medicines administration as well as having their competency to do this, regularly assessed. People were happy with the way that staff managed and administered their medicines. Staff were able to tell us about the requirements to support people with their medicines such as with skin patches or sedatives. One person told us, "They [staff] tell you what it [medicine] is and then make sure you have a drink and that you have swallowed them [the medicines]." Another person said, "The staff look after all my medicines." We found that when medicines were returned to the assigned pharmacy there was no documented signature of the person who had collected the medicines. This put staff at risk if medicines went missing as the accountability for the medicines had not been transferred in a safe way. Checks on people's medicines administration records (MAR) showed that staff had not documented the reasons people had refused their medicines. We saw that there had been many occasions when people had refused their medicines. However, we found that this was not always recorded by staff, which gave a reason as to why the medicine had been refused. This limited the provider's ability to identify any trends as well as inform any GP's response to this.

On Yeoman House there was no-one who had sufficient knowledge about the medicines administered and staff were unable to locate some people's previous MAR sheets. On one person's MAR we saw that a medicine that was prescribed to be taken at night had not been given to the person the previous night. Staff we spoke with could not explain why there had been a delay. On further investigation we found that there was not a robust system for checking newly prescribed medicines into the service.

We saw that medicines taken 'as required' did not have detailed protocols in place to give guidance to staff on how and when to support a person who required this assistance. Random stock checks on medicines showed that there were tablets unaccounted for. We found a discrepancy in the recording of two people's medicines records in March 2016. There was no evidence that this had been investigated prior to our visit. This was raised with the local authority safeguarding team during this inspection.

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

Staff said that pre-employment safety checks were carried out prior to them starting work and providing care. Checks included references from previous employment and a criminal record check that had been undertaken with the disclosure and barring service. Proof of current address and photographic identification had been obtained, and any gaps in employment history explained. However, in two staff recruitment files we looked at we saw that professional references from the two previous employers were not received. This meant that robust safety checks were not in place to make sure that staff were of a good character and that they were suitable to work with people living at the service.

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

People had individual risk assessments undertaken in relation to their identified health care and support needs. We saw that specific risk assessments were in place for, but not limited to, people at risk of falls, moving and handling, and poor skin integrity. Assessments also included, medicines, mental health, poor nutrition, and poor swallowing/choking. One person said, "I have a walking frame and they [staff] make sure I have it to hand." These risk assessments gave guidance to staff to help support people to live as independent a life as possible. They were in place to reduce the risk of people receiving inappropriate or unsafe care and support. Urgent reviews of people's risks were undertaken where there was a need. For example where a person had returned to the service after being in hospital. Records to monitor people deemed to be at risk were in place. However, we noted that one person in Yeoman House was assessed as being at risk of poor skin integrity. Prompts for staff documented that this person needed to be supported to move position every four to five hours. Records for the 12 April 2016 documented that the person was not assisted to change position for over seven hours. This meant people were at risk of harm because staff were not consistently following the guidance to reduce the risk of harm occurring.

Staff said that they had undertaken safeguarding training and records we looked at confirmed this. They demonstrated to us their knowledge on how to identify the different types of abuse and report any suspicions of harm or poor care practice. One staff member said, "I have had plenty of training including safeguarding and would always report any poor practice." Staff told us what action they would take in protecting people and reporting such incidents and knew how to escalate any unresolved concerns should this be required. We saw that staff had raised concerns about the staffing levels within the service. However, some staff told us that were not aware of where the safeguarding and whistle-blowing policy and procedures were kept.

Inadequate

# Is the service effective?

## Our findings

Poor staff practice that put people at risk of harm had not been identified and addressed by the provider. Our observations in Yeoman House and Harvester House showed examples of staff using poor and unsafe moving and handling techniques to support people. We saw people being assisted to move by staff using methods that could cause the person harm and raise their anxiety. For example in Harvester House, two staff members used a person's arms to enable them to stand. Risk assessments had not identified the equipment staff needed to use to help transfer the person. The person's care record stated that they were prone to bruising and at risk of skin tears. Prompts for staff in the care plan were that they needed to be extra careful when attending this person as holding their arms and legs could cause bruises and skin tears.

In Yeoman House we saw a person was supported to move by two staff that lifted the person by using their arms and legs as leverage. This was done without any communication or explanation to the person on what staff were about to do and why the person needed to move. There had been no consideration from staff with regards to the person's anxiety. We saw that when the person had been moved, staff then left the person without speaking or interacting with them and that this had caused the person distress. These concerns were reported to the area manager during this inspection. This meant that there was an increased risk that staff were not aware of people's current care and support needs.

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

Staff had mixed training opportunities. One staff member who worked in Harvester House said that they had not had any training for managing difficult behaviours or dementia. They told us they were to attend dementia training but that due to low staffing levels they had to cancel their attendance and work instead. We were told that in recent months that some staff had been moved at short notice to work within different houses. One staff member told us that they worked in Yeoman House and were then told they were moving to Harvester House with no discussion and consultation. This, they said, had caused some staff to leave. They also told us that they had not had specific training to meet the complex and individual needs of people living in Harvester House. Training, they said, was often scheduled but then cancelled. A deputy manager confirmed to us that the swap around of care staff had affected people's behaviours in Harvester House. They said that this change unsettled people and they saw an increase and change in people's anxieties resulting in behaviours that challenge. This was because a lot of the staff did not have experience of supporting people who live with dementia and present behaviour that challenges themselves or others. However, a staff member from Woolsack House, which provides personal care, told us, "I feel I have enough training for my role, although it is always good to have training and I will attend whenever there is some available." Records we looked at showed that staff training included, but was not limited to: basic food hygiene; behaviour that challenges; food safety awareness; infection control; medication awareness level1; medication management level 2; MCA and DoLS; moving and handling, safeguarding; nutrition and hydration; and care of a person with dementia. However, these records dated 07 March 2016 did not correlate with what staff told us.

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

We saw that people, including those with food allergies, sugar free or soft fork mashable diet, were offered a plated up choice of food as well as several drink options. However, we saw and staff confirmed that where people required a pureed diet that they were not offered a choice. We also saw that staff did not give people a choice of whether they would like sauce with pudding. In addition we saw that access to snacks throughout the day was restricted. The head of care told us that snacks were available in the kitchenettes within each house. They confirmed that to access these snacks people had to ask assistance from staff. In Yeoman House we observed that a vegetarian meal had to be specially requested at lunch time, for a person with this known dietary preference, as it had not been provided. In Harvester House we found that there were no finger foods, fruit or drinks available in the communal lounge/dining area. This meant that some people were not supported with as much choice as they could have been.

We saw that where people were at an increased risk of malnutrition that appropriate referrals had been made to a dietician, GP or speech and language therapist. Additional checks had been completed such as weighing people more frequently. However, in Yeoman House we found that a person returned from hospital and due to increased risk, records prompted staff on the 9 April 2016 that the person was to be 'weighed tomorrow'. However, no record of this being completed could be found. This meant there was an increased risk that the person was not being monitored as per the guidance given and that this could impact on their health and well-being.

We saw that staff respected people's independence with their eating and drinking. One person told us, "I love the food and there is always plenty." Another person said, "Can't fault the food. It's hot, tasty and if I want something else they [staff] get it pretty quick." A third person told us, "It [the food] always seems alright to me." We observed people being supported with meals in their room. Where people asked to have their meals later or an alternative, staff responded in a positive manner. However, we found that where people were at an increased risk of malnutrition that the quantities of food eaten were not recorded. We also saw that where people had only eaten a small part of their breakfast that the staff recorded that the person had eaten their meal. This increased the risk that this would be interpreted by other staff members that the person had eaten their whole meal. Staff told us that the space they had to record this information was limited. This put people at an increased risk of not being safely supported by staff or detailed records kept to monitor people with their nutritional needs.

One person told us that they usually had their lunch in the dining room. However, at 1.40pm we saw that they were still lying in bed, with only their head propped forward struggling to eat their meal from an over-bed table. Another person became distressed when the staff member supporting them with their meal had to leave. The person was struggling to eat their dessert and we saw that without staff assistance it had ended up in their lap.

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

Staff members told us they were supported by management within their houses. Staff said they attended staff meetings and received supervision of their work. Staff told us that during these meetings they could discuss issues of concern, their support and development needs and assess their performance. The provider's policy was that care staff were to have six supervisions a year, one of which could be an appraisal. Records we looked at showed that the number of supervisions staff received depended on which house they worked in. For example in Yeoman House, since December 2015 to the date of this inspection, records

showed that only 16 out of 37 staff listed had received supervision. This showed us that staff were not always supported within their roles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Appropriate applications had been submitted and in some cases acknowledged by the local authority to lawfully deprive people of their liberty. This was to help ensure that people were safely supported with their decision making. One unit manager said, "It's about prompting those people who can't decide for themselves what to wear and giving visual prompts such as holding up choices of clothes." However, not all staff had an embedded understanding of this legislation. We found that some staff's understanding of the MCA and the DoLS was limited. Records viewed showed us when and whether people could or couldn't make specific decisions. For example, when they wanted to go out and what they wanted to wear. However, information in these records was limited. For example, we saw documented that a person "can't make bigger decisions," without any clarification on what these were. This put people at an increased risk of not being supported to make decisions in line with the respective codes of practice.

We saw that people's GPs and relatives had, when required, been consulted on the safe application of covert administration of medicines [this is where people are not aware of being administered their prescribed medicines such as mixed in with their food]. The assigned pharmacist had also been consulted about safe ways of giving people medicines covertly. This was only done when a person had been lawfully deprived of their liberty and to help ensure the person's physical or mental wellbeing.

The majority of staff said that when they first joined the team they had an induction period which included mandatory training and shadowing a more experienced member of staff. This was until they were deemed confident and competent to deliver safe and effective care and support.

Nurses had been supported with evidencing their work as part of their revalidation. One nurse told us, "My NMC PIN renewal is due soon and they [the clinical lead] make sure I do this in good time." This showed the provider supported nurses to maintain their qualification.

People were referred to the most appropriate health care professional when needed. A visiting GP told us, "This is the best care home in the area as far as the referral of patients [people] is concerned. [Permanent] staff are very good at having people's notes and health care records ready for when I visit." They added that staff knew people's health needs well and if any changes in the person's health needed to be highlighted as well as staff adhering to their advice. Staff said that they had support from the local GPs, specialist nurses such as tissue viability as well as community nurses. We found and people confirmed that they saw the GP when they needed. People could be assured that the staff would take action to reduce and prevent any risks associated with their health.

Inadequate

# Is the service caring?

## Our findings

Leadership of the service did not support staff to be caring. We found that in Yeoman House and Harvester House staff were busy concentrating on carrying out the care and support tasks that were required. We saw that staff were caring but due to significant shortfalls in the service the culture was not a caring one. We observed that staff had little or no time to interact positively with people they were supporting. Some staff had adopted a task orientated approach to care and support to deliver the assistance required. A staff member told us about the effect low staffing numbers had on people they were supporting and on staff. They said that, "You can't be the carer you want to be." Another staff member told us that, "They [staff] do not have time to spend any quality time [with people]…I like to think we try our best and give good care." A third staff member said, "Not everyone who wants to get up is up. Five [people] are not yet washed [at 2.45pm]…one person takes more than half an hour…..it's chaotic, it's so upsetting. We have complaints from the unit manager and families….it's scary…it's pretty much always the same." A relative said, "The staff try so hard to care for everyone. They are just rushed off their feet." Another relative told us, "There is a high turnover of staff, staff do not seem to stay long, there doesn't seem to be any continuity, regular staff are chopped and changed around and this is hard for residents to build relationships."

Observations showed that in other houses [Hayward House and Woolsack House] staff were caring and considerate to the people they were supporting. Examples of compassionate and thoughtful care were observed on occasion. These included staff asking a person where they would like to sit for lunch. We saw staff asking people if they were ready to be assisted to go to lunch by kneeling down to the eye level of people who were seated. This was as well as speaking clearly and near to the person so that the person understood and heard what staff were saying. Another example was a person who needed a plaster which staff got for them and they confirmed that the person was not in any pain. Staff were heard asking people, when assisting them with their meals, "Is it alright if I put your [tabard] on?" and "Do you want one?" Another staff asked a person, "Would you like me to cut your chicken up?" and "Would you like any more?" and "Are you enjoying your meal?" One person told us, "They [staff] are all very nice. I love it here." Another person said, "Staff always treat me respectfully - they are very good." Person centred care was demonstrated and staff showed us that they knew the likes and dislikes of people they were assisting.

People, and their appropriate relatives, were involved in the development of people's care plans and records. This was during the pre-admission assessment stage when agreeing the person's care that was to be provided at the service. One person said, "I see my papers [care plan] and they [staff] talk about what I am happy with and any changes I need. I don't change much as the staff know me so well."

We found that some people were not supported in the way their care plan stated they should be. This meant that for some people there was a risk that their care was not as person centred or, current as it could have been. It also meant that people were at an increased risk of unsafe care when agency or new staff provided their care because care plans were not up to date to reflect the person's current needs.

People valued their relationships with staff. One person [pointing to staff] told us, "They are nice to me and always ask how I am." Another person said, "It's nice here just like the staff." We observed several examples

of staff seeking assurance as to people's wellbeing. One person became upset [due to their anxieties] we saw staff intervene, offer additional support and explain to the person when staff would help them with their request. A few minutes later we saw staff help the person and later in the day they told us that they were very pleased with the support provided.

We saw and people confirmed that staff were always polite and spoke to them in a respectful way. Examples included ensuring people's private conversations were respected and also when people wanted to be on their own. Staff gave people time to consider their decisions as well as allowing people to do things at their own pace. All staff were passionate about making a difference to people's lives. One staff said, "I have worked here for over four years and I love every day and the difference I make to people's lives."

Staff described how they respected people's privacy and dignity. This included distracting people with general conversation during the provision of personal care. Other ways staff used to respect people's dignity was by gaining permission to enter their room and closing doors or curtains when delivering personal care.

We found that people had relatives, friends and representatives who acted as an advocate for them if required. Advocacy is for people who cannot always speak up for themselves and provides a voice for them. Staff were aware of the support organisations such as Age UK as well Independent Mental Capacity Advocates [IMCA]. This is a requirement under the MCA where people's only representative could be paid staff. Where people's DoLS had been authorised we saw that a legal representative was appointed such as a close family member. This showed us that staff took steps to ensure people's wishes, needs and preferences were ascertained and respected where people were not able to speak up for themselves.

People told us, we saw, and staff confirmed, that visitors could call in at any time people were in the service. One person told us, "I have children and grandchildren and they all visit. My [family member] can only get here every few weeks but it's nice to see them."

We found three examples where people who had moved from their own home or hospital had not had their DNACPR reviewed. Resuscitation Council UK guidance is that these should be reviewed when a person changes location where they live.

Inadequate

# Is the service responsive?

## Our findings

During our inspection we saw that people did not always receive care that was responsive to their needs. This was because there weren't sufficient staff available which meant that the approach of staff was task driven.

In Yeoman House we saw that the first person was assisted from their bed by staff at 10.50am. A staff member was heard to say, "First person up – hooray." People told us that this was not their choice or their preference. One person said at 1pm, "I'm normally got up for lunch, but today I have been neglected. I'm all dressed but they [staff] haven't had time [to help me out of bed]." Another person told us that they often did not receive their personal care from staff until the afternoon. Records we looked at confirmed this. They went on to tell us that there was a regular delay in staff responding to their call bell, "They [staff] can come to the door and ask what's wrong and say they'll go and get someone but then not come back." The person told us that this had previously resulted in an incident which left the person feeling embarrassed and undignified. They told us, "I've no complaints about the staff but at the end of the day it's down to a shortage of staff." A relative said, "The staff are wonderful it's a shame there is not enough of them." Another relative told us, "The girls [staff] try so hard but there isn't enough of them. You can see that some people have not even got up yet. Some people need a lot of help."

In the communal lounge in Harvester House at 12.50pm we saw a person getting increasingly upset. This then increased the anxiety of other people in the communal lounge and we observed objects being thrown at the person by another. The person's care record stated that noise exacerbated their anxiety and that staff should support the person by moving them to their room. It went on to say that staff should then spend time on a one to one basis with the person, until the person's anxiety decreased and they became calm. Staff told us that they did not have enough staff to support the person within their room and assist other people who required help with their meals and to go to the toilet. This concern was raised with the local authority safeguarding team during this inspection.

From what we observed and what staff told us, we saw that there were few opportunities for staff to spend meaningful time with people in Yeoman House and Harvester House. Daily care notes recorded activities such as "had a chat about [person's] relative" with no further detail of what the discussion was about or whether people had enjoyed this. The vast majority of activities were provided by the activities staff members working within the houses. During this inspection we saw activities such as movement to music taking place. An activities co-ordinator told us that they organised trips out to the local garden centres and had pub lunches for people to help promote their social inclusion. However, in one person's record we saw that there had been no activities or additional stimulation for 11 days. There had been many occasions where the activities recorded were every two to three days. In Harvester House we saw that 14 people were sitting in the lounge/dining area. There was background music playing and tea/ coffee and biscuits being served, with little or no engagement or social interaction. Staff we spoke with confirmed to us that, "We don't have time for anything else."

We saw that staff supported people to attend services associated with their faith. Regular services were held

at the service for people to attend should they choose to do so. We noted that a person was assisted to access the local community to attend a religious service. However, staff told us that this was requested and arranged by the person's social worker. They said, "This is something the social worker said we have to do, so we have to do it."

As part of people's care needs assessment an initial meeting was held with the person, their representative or family member. This, in conjunction with the local authority's single assessment process formed the foundations of people's care and support needs plan. We saw that people were given the opportunity to give their views about what they thought their levels of independence were. This was during day-to-day contact with staff as well as more formal care plan reviews. In addition each person was nominated as the 'resident of the day'. This was where their care was thoroughly considered, reviewed and changed when required by staff. This was also an opportunity for newer staff to get to know the person they were assisting better. For people who were living with dementia, this helped formulate what made a difference to the person's life. Examples of this included people's likes such as close friends, knitting, pet rabbits as well as dislikes including types of food or allergies to certain foods.

Care plans gave the information staff needed regarding the ways people communicated. For example, verbally or example shown/visual prompts and subjects of reference. We saw that individualised memory boxes had been place adjacent to people's rooms in Hayward House. This was to help people living with dementia to identify where they were and where their room was. Items included information about what work people had done in the past and holidays they had been on as well as photographs of their family members.

People's personal history was recorded where this was available. This included the important aspects of people's lives and what was most precious in their memories. For example, family members, their working lives and achievements. Items for people to pick up and engage with were readily available such as information about people's war time experiences, as well as books and diaries from the era people had lived; sewing materials, pet and doll therapy which people liked.

On speaking to staff they told us that they did not have time to read people's care records in full. One staff member said, "I never really read the care plans, I can access them but don't have time." Another staff member said that they did not get time to read care plans. If they needed information they would ask the nurse of read specific parts of a person's care record but not read it all of the way through.

Staff told us that if a person raised a concern or complaint that they would, in the first instance, try to resolve the matter themselves. They would then record this in the daily 'take10' meeting or at a staff shift handover, using the notes in the daily diary. One person told us, "I am happy here and I don't have anything to moan about these days. It's all good." Another person said, "I would speak to staff if I was unhappy and they would help me." However, a relative told us that they did not feel that their complaint had been dealt with to their satisfaction, and in a timely manner. We looked at recent compliments and complaints received by the service. We found that, the provider could not demonstrate whether complaints had been resolved to the person's satisfaction.

Inadequate

# Is the service well-led?

## Our findings

There had been no registered manager in place to oversee the running of the service since March 2015. There had been two home managers recruited since then with the intention that they complete the application process to become the registered manager. However, both of these managers had, at different times, resigned. One staff member said, "I only met the manager for the first time last week and now I understand she is leaving." This meant that the provider did not have adequate and stable management and leadership in the service to provide people with a high quality of care.

Following the number of recent safeguarding concerns raised and whistle-blowing reports received by both the local authority and the Care Quality Commission a large scale enquiry was being carried out by Peterborough City Council adult social care team. This has resulted in an embargo on people moving into the service for people requiring support with personal care. Cambridge and Peterborough Clinical Commissioning Group had also put an embargo in place for people who required nursing care. A BUPA action and sustainability plan had been put in place. This action plan documents all the improvements needed as identified by the safeguarding concerns to ensure that the home provided safe care and support to the people living there. People and relatives did not feel the provider had kept them informed of the reasons for the embargo or what they were doing to ensure the service improved. One relative said, "I know the service has stopped admitting people, and I want to know why. We were told that it was to do with the safety. I don't feel we were given a very good explanation; don't feel we got to the bottom of it. I do not feel that BUPA have been open and transparent, they put notices on the board, but there is little in the way of explanation."

Quality monitoring systems to identify areas of risk and trends within the service did not always identify or resolve the areas found to be requiring improvement. We saw that each House carried out their own quality monitoring on areas of risk such as, medication administration records, compliments and complaints received, safeguarding concerns and incidents. However, during this inspection we identified a number of shortcomings in the standards of care that had not been identified by these monitoring systems. These included low staffing levels in two out the four Houses that meant that people's care needs were not met in a safe and timely manner. Staff told us that if a person's behaviours increased and this required extra staff that the request for these were not always supported. One staff member said, "I do 12 hour shifts like most staff and sometimes I only have time to complete people's personal care but then I don't have time to write up notes or do other management tasks." We saw that incident forms have been completed by staff to raise these concerns.

The quality monitoring process had not identified that staff had not completed all of their training, and that staff supervisions were not always carried out in a timely fashion. We identified poor staff moving and handling techniques were being used that put people at risk of harm. These audits had also not found that robust safety checks were not always undertaken with regards to safe staff recruitment.

The provider had not completed adequate audits of the records held for people. We identified that there were incomplete monitoring records kept or conflicting information in care plans for people deemed to be

at risk. For example, we saw that a person, who had a DoLS in place, still had a form that stated the person had mental capacity to make day-to-day decisions. This meant that there was an increased risk of staff miss-interpreting these records and people not receiving the care and support they need.

The majority of records were held securely. However, we found that in Yeoman House a file with personal information in it was placed outside of a person's room. This increased the risk of people and visitors to the service being able to view these confidential records without permission.

We found that staff had identified that improvements were required such as where people had been identified as hoarding their medicines. We saw that actions taken including using certain staff as well as covert medicine administration had resolved this situation. However, the provider did not provide appropriate clinical leadership to make sure that people received effective and safe care. This was because the process for auditing medicines had not identified all of the issues found during this inspection. The last medicines audit for Yeoman House was dated 11 February 2016 and had a compliance score of 93.6%. However, during this inspection, we found numerous concerns around the safe management of people's medicines in this house that were not identified by the audit.

We saw that a daily 10 point check had been completed for the medicines administration. Checks included that people's medicines were correctly recorded and disposed of when required. However, we found that these audits had not identified that the reasons for people refusing their daily prescribed medicines had not been recorded. The clinical lead told us that nursing staff are supposed to do this but not all of them were adhering to this policy. This meant that the quality monitoring systems in place had not identified all areas of concern and/or improvements required, implemented and sustained.

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

Records we looked showed that staff meeting occurred. However, meeting minutes were not always dated. One staff member said, "I have not been to any staff meetings since I started in October last year [2015]." Some staff were able to question the practices on the units they worked. This was though daily contact with managers as well as at supervisions. One staff told us, "I couldn't do my job without the support [name of home manager] provides." Another said, "It doesn't matter what our concerns are or how small they are, I can always rely on [name of unit manager] to be there when I need them. They are at most a phone call away. Staff all confirmed that the current home's manager visited the houses at least twice a day. One staff member said, "This manager is the best we have had for a while they fight our corner." However, during this inspection we found that some staff became emotional when talking to us about the impact the change in staff rotas and low staffing levels had on them and the people they supported. One staff member told us that one Friday evening, with no consultation or discussion with staff; staff were scheduled to work in different Houses. They told us that when staff came in the following Monday and they found that they were allocated to different houses, it was chaotic. This was because staff did not know where they were supposed to be and that some staff went off sick.

People and their relatives were given the opportunity to feedback on the quality of the service provided. Surveys for people, and their relatives were sent out to gather opinions on the service. The latest report we saw collated the feedback received from the December 2015 survey. This showed a 64% overall satisfaction with the service provided. Areas for improvement identified included the quality of care people received and that some people were not happy or content living at the service.

Staff showed us that they understood their roles and responsibilities to people who lived in the service. They

knew the lines of management to follow if they had any concerns to raise. They demonstrated to us their knowledge and understanding of the whistle-blowing procedure. However, the overall culture across the service was not open and inclusive. Staff were not consistently given the opportunity to feedback and when they did, they were not confident that their concerns would be taken seriously or addressed. Staff were not involved in the continual development and improvement of the service.