Care Quality Commission

Charing Cross Investments Limited

Temple Ewell Nursing Home

Inspection report

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Date of inspection visit: 16 and 21 July 2015
Date of publication: 22/09/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection visit was carried out on 16 and 21 July 2015 and was unannounced.

Temple Ewell Nursing Home is a privately owned care home providing nursing care and support to up to 44 adults who have nursing needs and who may also be living with dementia. The rooms are located on two floors; the main entrance is on the first floor accessed by a lift. There are private gardens with seating, patio areas and parking. On the day of the inspection there were 38 people living at the service.

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

Although people told us they felt safe, risk assessments to support people with their mobility were not detailed enough to show how the risks should be managed safely. The assessments also lacked guidance for staff to support

Summary of findings

people with their behaviour, so that these risks could be minimised. This left people at risk of not receiving interventions they needed to keep them as safe as possible.

There was insufficient staff on duty to ensure that people's needs were fully met. People, relatives and staff told us that on occasions there was not enough staff on duty, especially at weekends.

Records did not confirm that the required training had been provided for all staff, and further specialist training, such as dementia, needed to be carried out for all staff. Over fifty per cent of staff held recognised qualifications in care or were completing the award. Staff met regularly with the registered manager to discuss their role and any concerns they had.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection the registered manager had applied for a DoLS authorisation for two people who were at risk of having their liberty restricted. Not all mental capacity assessments were in place to assess if other people needed to be considered for any restrictions to their freedom.

When people were unable to make important decisions for themselves, relatives, doctors and other specialists were involved in their care and treatment and decisions were made in people's best interest. However, information was not always recorded to confirm how people had given their consent or been involved in decisions that had been made, for example, when bed rails were in place to prevent a person getting out of bed.

Care plans lacked detail to show how people's personalised care was being provided and care plans had not been reviewed or updated since March 2015. Care plans did not record all the information needed to make sure staff had guidance and information to care and support people in personalised way. Records were not always completed accurately or properly.

People and relatives told us the staff were kind and respected their privacy and dignity. However, this was sometimes being compromised by lack of staff, which made the care more task orientated than person centred. Staff were familiar with people's likes and dislikes and supported people with their daily routines.

Although there were some planned activities, on the day of the inspection some people remained in their rooms and were not engaged in activities. Staff were familiar with people's likes and dislikes, such as what food they preferred.

People told us that they felt safe living at Temple Ewell. The majority of staff had received safeguarding training and they were aware of how to recognise and protect people from the risk of abuse. Staff knew about the whistle blowing policy and were confident they could raise any concerns with the manager or outside agencies if needed. Staff recruitment systems were robust and checks had been made to ensure new staff did not pose a risk to people living at the service.

Staff were receiving support from their manager through one to one meetings. Yearly appraisals were used to ensure staff had the opportunity to develop and identify their training needs. There were regular staff meetings so staff could voice their opinions and discuss any issues.

Checks on the equipment and the environment were carried out and emergency plans were in place so if an emergency happened, like a fire, the staff knew what to do.

Accidents and incidents had been recorded and the necessary action had been taken to reduce the risks of them happening again.

Staff were attentive and the atmosphere in the service was calm and people appeared comfortable in their surroundings. Staff encouraged and involved people in conversation as they went about their duties.

People told us that they enjoyed their meals. If people were not eating enough their food was monitored. If required a referral was made to a dietician or their doctor, and supplements were provided so that they maintained a healthy diet.

Medicines were stored and administered safely. Staff had been trained and demonstrated good practice in medicine administration. People's health was monitored and when it was necessary staff contacted their doctors or specialist services.

The complaints procedure was on display to show people the process of how to complain. People, their relatives and staff felt confident that if they did make a complaint they would be listened to and action would be taken.

Summary of findings

There were quality assurance systems in place which had not always been effective. Health and safety checks and maintenance checks were regularly carried out. The service had systems in place for people to voice their opinions on the service and care being provided.

Staff told us that they were supported by the management team. They said the managers and nurses were approachable and that there was a culture of openness within the service. They told us they were listened to and their opinions were taken into consideration.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

There was not always sufficient staff on duty to make sure people received the care they needed.

Risks to people were assessed but there was not always clear guidance in the care plans to make sure all staff knew what action to take to keep people as safe as possible.

Recruitment procedures ensured new members of staff received appropriate checks before they started work.

People's medicines were managed safely.

Staff knew the signs of abuse and had received training to ensure people were protected from harm.

Is the service effective?

Requires improvement

The service was not always effective.

Staff received induction training and on-going training in relation to their role. Not all staff had completed specialised training, such as training to support people with dementia.

There was a lack of mental capacity assessments and people had not always signed their consent forms to show they had agreed with their care.

Staff were knowledgeable about people's health needs; however, care plans did not always reflect the care being provided to confirm people had received the care they needed.

The service provided a variety of food and drinks so that people received a nutritious diet.

Is the service caring?

Requires improvement

The service was not always caring.

People and relatives said people were treated with respect and dignity; however, we saw staff move one person in an undignified manner.

People and their relatives were able to discuss any concerns regarding their care and support.

People were supported by their family to be involved in their care and if required advocacy services were available.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

Families supported their relatives to be involved in their care planning. However, care plans lacked detail to ensure person centred care was being delivered. The care plans had not been reviewed consistently and updated.

There were mixed views with regard to the activities in the service, some people were satisfied, while other people thought they could be improved.

People and their relatives said they would be able to raise any concerns or complaints with the staff and registered manager, who would listen and take any action if required.

Is the service well-led?

Requires improvement

The service was not always well-led.

Quality monitoring systems were in place and shortfalls in the service had recently been identified but action to improve the service had not started at the time of the inspection.

Accidents and incidents were recorded and action taken, and summarised to look for patterns or trends to reduce the risk of reoccurrence.

Records were not always accurate or completed.

Staff told us that they felt supported by the manager and that there was an open culture between staff and management.

Temple Ewell Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 16 and 21 July 2015 and was unannounced. It was carried out by one inspector and a specialist adviser with a background in nursing care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. We also looked at information received from social care professionals.

We looked around all areas of the service, and talked with ten people who lived at the service. Conversations took place with people in their own rooms. We observed the lunch time meals and observed how staff spoke and interacted with people.

We talked with four relatives who were visiting people; eight care staff and the cook. We also spoke with the registered and deputy manager of the service.

We spoke with two health care professionals.

The previous inspection was carried out in September 2013. No concerns were identified at this inspection.

Requires improvement

Is the service safe?

Our findings

People felt safe living at the service. People said: "Yes, I really do feel safe here". A family member told us that they were confident their relative was safe living at the service.

Risks to people had been identified and assessed but guidelines to reduce risks were not always in place and were not clear. Risk assessments to support people with their mobility lacked detail. For example, one person's risk assessment identified that two staff members were needed for support and to use a slide sheet. The assessment also noted this person was unable to weight bear but there was no guidance for staff to show what equipment and size sling to use to make sure this person was being moved safely. This person was also living with Parkinson's disease but this condition had not been included in the risk assessment to show how this affected the person's mobility. One care plan stated to use the hoist with sling and slide sheet to help the person out of bed but there was no detail on how to do this safely, how to re-position the person, sit them up in bed or which sling to use and how to apply it. Another plan stated that a person waved their hands whilst being moved using a hoist, making the manoeuvres unsafe, the risk assessment did not tell staff how to manage and reduce these risks. Reviews of risk assessments had not been carried out since March 2015, therefore people's changing needs had not been further assessed or recorded.

Risk assessments around challenging behaviour acknowledged the risk of the behaviour but did not give any strategies for managing it. It was also recorded that some people 'may become aggressive' but there were no risk assessments in place to show staff how to positively manage this behaviour.

There were no bathing risk assessments in place. The baths were very low and there was no guidance for staff to show them how to reduce the risks and support people to bath safely.

The provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people and supporting people with their behaviour. This is in breach of Regulation 12 (2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us that sometimes the service was short staffed: One person said: "We may be short staffed but the staff we have are marvellous".

There was insufficient staff on duty to ensure that people's needs were fully met. People and staff told us that, at times, there was not always enough staff on duty. The registered manager told us that optimum staffing levels for the service had been assessed as nine staff in the morning and six staff in the afternoon This varied as the service provided end of life care and most of the people required more than one member of staff to support them with their personal care and mobility. At the time of the inspection here were 38 people living at Temple Ewell.

The rota for the month of July showed that there was only one occasion when this optimum staff levels was achieved. The lowest staffing levels were on Sunday 19 July 2015 when there were seven staff on am and four staff pm. With the number of people living at the home, staff would not be able to fully meet their needs. For example, if more than one person who needed two staff to support them needed to receive personal care or go to the bathroom, apart from the nurse on duty, there would be no staff left to respond to other people's care needs. There was also a high number of people who needed support to eat, which further reduced the number of staff available to meet people's needs at meal times.

The service provided end of life care which could increase the need for additional staff. There was only one nurse on duty during the night and this raised concern due to the high level of end of life care. The registered manager told us staffing levels were assessed to the needs of the people and increased when required, however, we did not see any additional numbers on the July staff rota. One person told us that when the service used agency nurses they did not attend to their needs as well as the permanent staff.

Relatives told us that they felt there was a lack of staff especially at weekends. The service did use agency staff to cover some of the shifts but they were not routinely used to bring the staffing levels up to the agreed optimum level of nine in the morning and 6 in the afternoon.

Staff told us that due to sickness and vacancies they were often short staffed, especially at the weekend, and found it difficult to fully meet people's needs. They said agency staff were used as and when required but they were not always available at short notice, when staff went sick or at the

Requires improvement

Is the service safe?

weekends. One member of staff said: "The quality of care all depends on staffing levels, when we are fully staffed we run this place as it should be, but it is hard to do this when we run short".

The deputy manager told us that the service was able to use agency staff to cover and they requested the same staff so that people had care from staff they knew. The amount of agency staff used in the month of July was , nursing staff, 12 days, care staff, 16 days and nine nights. There was currently a vacancy for two nurses and the service was also recruiting care staff.

The provider did not always have sufficient numbers of staff on duty to meet the needs of the people. This is in breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff recruitment procedures were thorough, and included required checks, such as ensuring the applicant had provided a full employment history; proof of their identity; satisfactory written references; a Disclosure and Barring Service (DBS) criminal record check; and proof of qualifications obtained. A record was kept of the interview process. Staff had job descriptions and contracts so they were aware of their role and responsibilities as well as their terms and conditions of work. Successful applicants were required to complete an induction programme and probationary period.

Staff had received training in how to safeguard people. Staff were able to demonstrate their understanding of what abuse was and who to report concerns to if they had concerns about people's safety. They were aware of the whistle blowing policy and spoke confidently about reporting any concerns they may have to their manager and other external agencies, such as the local authority. However, we found that a person had been admitted to the service with several injuries and we noted that a safeguarding alert had not been raised. We spoke with the registered manager who was not certain if the previous placement had raised these concerns. On the second day of the inspection it was confirmed that a safeguarding alert had been raised and the local authority were processing this information.

The majority of accidents/incidents had been recorded and reviewed monthly to look for patterns or trends to reduce the risk of them happening again. However, care records showed that one person had an incident on 14/07/2015 which resulted in a skin injury. There was no incident report on record at the time of the inspection.

People and relatives told us that the home was always clean and tidy. One relative commented that the housekeeping staff did a good job and they had cleaning schedules which included the skirting boards. The service was clean with cleaning schedules in place which included a weekly 'deep clean" for each person's bedroom. There were hand washing facilities in the clinical room and bathrooms and people's rooms with liquid soaps and paper hand towels. There were aprons, gloves and hand gel throughout the service and staff were observed using these. Staff were seen hand washing in-between helping people with personal care.

There was a high usage of hoists but people did not have their own individual sling and the size of the sling for each person was not recorded. Using one sling for more than one person could be an infection control issue. There was also a risk that new or agency staff may use the wrong sling as there were no clear guidelines to show exactly what size sling should be used. The registered manager told us that individual slings were in the process of being ordered for each person. There was one hoist for each floor and staff told us that they could do with more equipment as so many people required the hoist to move them safely.

There were records to show that equipment and the premises received regular checks and servicing, such as checks of the hoists, boilers, electrical system, nurse call system and temperature of the water. The maintenance person carried out a daily health and safety check to ensure the premises remained as safe as possible. Systems were in place to reduce the risk of fire and records were in good order. Environmental risk assessments were in place for each room and rooms were checked weekly to ensure equipment was working. These included ensuring that electrical and gas appliances at the service were safe. People had a personal emergency evacuation plan (PEEP) in their rooms. A PEEP sets out the specific physical and communication requirements that each person had to ensure that they can be safely evacuated from the service in the event of an emergency.

People received their medicines when they needed them. There were policies and procedures in place to make sure that people received their medicines safely and on time.

Requires improvement

Is the service safe?

We observed nurses giving people their medicine safety and routinely offering people pain relief medicine. Two people had their medicine administered in thickened fluids or yogurt to assist swallowing. One person sometimes refused their medicine and this was recorded and accepted as this person had capacity to make this decision. The nurses also made sure that one person had their pulse recorded before they took their medication to ensure the person was safe to take their medicine.

Medicines were clearly labelled with name, administration times and routes, dose, expiry date and batch numbers.

The records showed that medicines were administered as instructed by the person's doctor. Medicine Administration Records (MAR) charts were clearly signed and dated and reasons for non-administration recorded.

Medication was stored securely, including items which needed to be kept cool in the fridge. The fridge and room temperatures were checked daily to ensure medicines were stored at the correct temperatures. There were suitable procedures in place for destroying medicines which were no longer required, and records were correctly maintained.

Requires improvement

Is the service effective?

Our findings

People and their relatives were happy with the care and support they received. People said: "I get everything I need here". "The staff are really good and help me with everything". "No one could do more for us like they do here".

Relatives told us that the staff received the training they needed. They told us that communication with the staff was very good and they were kept up to date with their relative's changing needs.

Staff had received on line training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The Act protects people who lack mental capacity, and assesses their ability to make decisions or participate in decision-making. The service had applied to the local authority for deprivation of liberty safeguards to be assessed. Staff were aware that some decisions made on behalf of people who lacked capacity should only be made once a best interest meeting had been held. However, one person had short term memory loss and had signed to agree to have bed rails, there was no evidence of a mental capacity assessment to ensure this person understood and agreed to this decision. There were advanced decisions in place by people who were receiving end of life care. One plan lacked evidence to show how they had been involved in the decision to resuscitate them, the forms had been completed and discussed with the family but there was no evidence to show that this person had a mental capacity assessment to ensure that the decision was being made in their best interests. Another person was placed in a chair which was tilted backwards to ensure they did not fall out. There was no assessment to confirm that this had been agreed and the person had consented to use this chair.

There was a lack of information to show how people had agreed with their care to be provided. Care plans did not show how people had been involved in their care planning and consent forms had not been signed to show that they had agreed with the care to be provided. Some people who lacked capacity stayed in their rooms and there was no indication that assessments had been made to ensure that this decision was made in their best interests.

The provider had not ensured that care and treatment was provided with the consent of the person and had not acted in accordance with the Mental Capacity Act 2005. This is in breach of Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People and relatives told us that the staff knew how to care for them well. One relative told us that the service had a good mix of trained staff. They said that some of the senior staff were very good at training the new staff. New staff told us they had received a good induction when they started work at the service. The new Care Certificate had been introduced which is the recommended training from the government for health and social care staff. Staff confirmed that they shadowed experienced members of staff to gain experience in the role they would be undertaking. Over half of the staff had obtained or were in the process of obtaining a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To achieve a Diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

Staff told us that they received regular training. The registered manager told us that the training matrix had not been updated to reflect the training which had been given, therefore, we could not evidence that all of the training had been provided. For example, the training matrix showed that 6 staff required fire training, 7 required infection control training, 9 health and safety training, 7 infection control, 11 safeguarding training and only 13 staff had received basic food hygiene. The registered and deputy manager provided the majority of training for all staff and a team leader was a moving and handling assessor. Staff told us that they had received training such as moving and handling, fire, food hygiene, first aid and infection control, but this was not fully evidenced on the training matrix to confirm this had taken place.

Specialist training, such as dementia training, had been provided but not all staff had received this training. The deputy manager was in the process of cascading 'Principles and Practice of End of Life Care' for non-registered health and social care staff training for all staff.

Requires improvement

Is the service effective?

The provider was not ensuring that all staff received appropriate training to enable them to carry out the duties they are employed to perform. This is in breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

Nurses had received training such as venepuncture, syringe drivers and catheterisation. Some of the training including watching DVD's and on line training.

Staff regularly met with the manager for supervision and appraisals to discuss their personal development needs and any areas where they could benefit from further training. Staff meetings were also held to give them an opportunity to discuss the service.

People's health was monitored and when it was necessary health care professionals were involved to make sure people were supported to remain as healthy as possible. People had access to GP's, consultants, specialist nurses, dieticians, physiotherapists and speech and language therapists. People had regular appointments with chiropodists, dentists and opticians.

Beds with air flow mattresses supported people to keep their skin healthy and special cushions were available for people to sit on. However, some people had alternating pressure mattresses for pressure relief due to being assessed as at high risk of damage to their skin. There was no record of the setting to be used for each person, which would vary depending on their weight and whether they were nursed sitting up or lying down. There was also no system in place to check the settings daily to make sure they were correct, or had not been accidentally reset.

People receiving end of life care were being supported by their doctor and hospice. Palliative Specialist Nurses provided advice on pain control, having liaised with doctors to ensure people were being supported at this time. Staff were aware they had access to the hospice twenty four hours a day telephone service, should they require further support. People's care plans showed prompt action was taken to address people's symptoms and the doctors, hospice and families had been consulted to ensure that people were receiving the care they needed. For example, staff had involved the doctor, the community mental health care team and hospice to support a person receiving end of life care to cope with their depression and manage their nausea.

Nutritional risk assessments were completed to make sure people were receiving the food they needed. The dietician had previously seen one person in hospital and given advice which was in the care plan for staff to follow. A speech and language assessment had also been undertaken for swallowing advice. We observed that the person was receiving thickened fluids and pureed food in line with the guidance given. People who had been assessed as not eating or drinking enough had charts in place to record what percentage of their meal they ate each time. This was used to provide information to health care professionals should the person require food supplements to boost their diet. When people had lost weight, appropriate action had been taken to inform health care professionals so that people would receive the advice and support they needed with regard to their dietary needs.

We observed lunch and saw all the food was freshly cooked and people were given choices off the menu. The meal served looked appetising and people told us they enjoyed it. People were offered a choice of dessert and if they did not understand staff showed them the two alternatives so they could pick one. Lunch was served and eaten and nobody was rushed, people enjoyed their meal. People said: "The food is pretty decent here". "I enjoy the food". "I like the food, it is really good".

We spoke with the cook regarding the menus and choices available. They were able to tell us details of people's preferences and dietary requirements. There were food charts to monitor people's choices and the amount of food they had eaten. Likes and dislikes were recorded in each person's care plan together with special dietary needs. One person said: "The cook has always been here, she is a very good cook".

Requires improvement

Is the service caring?

Our findings

People and relatives told us the staff were kind and caring. People said: "Yes we have choice, I can pick and choose when I want to go to bed". "The staff are "gold" here, "they are really lovely". "No one grumbles at you here, the staff are easy going and do anything for me". "The staff go backwards and forwards to keep me happy, we are lucky to have so much help". "Everyone who passes my door stops to chat even it is only for a few seconds". "The staff are always very polite and respectful".

A visitor told us that the staff were very pleasant and really helpful to people. They said they had observed when people needed anything the staff responded as quickly as possible. Relatives said: "The staff work really hard, I don't know how they do it. I am very satisfied how they look after my relative". "The office staff are brilliant, nothing is too much trouble, they always keep in touch about my relatives care". "One nurse in particular is exceptionally caring and full of compassion". "The nursing staff are calm and there is a comfortable atmosphere in the service".

Staff encouraged and supported people in a kind and sensitive way to be as independent as possible. However, some care plans lacked details to show staff what people could achieve to support them to be as independent as they could be. Many of the people living with dementia stayed in their rooms and there was no indication if they had agreed to this decision or how staff made sure they were being supported to reduce the risk of them becoming socially isolated.

The service was part of the dignity champion national scheme. Dignity champions ensure that everyone is treated with **dignity** as a basic human right, not an optional extra. People told us they were treated with privacy and dignity and staff always respected their wishes. They said and we observed that staff knocked on their bedroom doors before entering. However, when a person was being moved from the lounge to their bedroom two members of staff moved them backwards in their chair without speaking or explaining that they were going to move them. This did not demonstrate that dignity was upheld at all times. Staff told us that sometimes their role became more task orientated than personalised as there was a lack of staff, which impacted on their time to make sure people had their full care needs met.

People's rooms were personalised with their own belongings. One person told us how they liked their large room and was happy with the service. One person said: "I like being in my room, I even have my lunch here".

Staff spoke with people politely and warmly. They made sure that people understood when they were completing their routines, for example, the nurse introduced herself to one person, explained that they had met previously and went on to tell them about their medicines.

Staff were observed speaking to a person who was non-verbal, smiling and touching their shoulder as they spoke with them. Staff spoke with people whilst carrying out their duties; they stopped and chatted to see if people needed anything, such as a drink.

Staff were observed talking to people in their rooms, introducing themselves and stating the purpose of their visit. They spoke to people kindly and used smiles and touch appropriately.

Staff supported people to make decisions, such as what they wanted to eat or wear. One relative told us how they respected their relative's wishes by making sure they had matching clothes and their appearance was checked to make sure they looked how they wanted to be. Advocacy services were displayed on the notice board should anyone require to use this service for independent support. Each person had a key worker who was responsible for building relations with family and routinely checking with the person to see they had everything they wanted, such as toiletries, etc.

We overheard one member of staff sensitively speaking with a person telling them that they were going to move their hair as it was falling over their eyes and asking if it was ok to do this. The person responded and thanked the member of staff.

People told us that they could see their visitors in private if they wished. Relatives confirmed they were made welcome and could visit their family member at any time. The service had a family room for relatives and visitors where they could maintain their privacy and make their tea. The room led out to the garden and had comfortable furnishings and a television. A folding bed was also available if families wanted to stay close to their relatives.

End of life care plans showed people's preferred place to be cared for at this time and where they wanted to pass away,

Requires improvement

Is the service caring?

their preferences for burial or cremation and choice of funeral directors were recorded. Advanced care planning provides people and their relatives with an opportunity to talk openly and make their last wishes known. This is promoted in the 'The Leadership Alliance 2014, One chance to get it right, Care of dying people". The service was also applying the quality standard 13 in line with National Institute of Care Excellence (NICE) guidelines which outline standards to improve the quality of end of life care. Staff had received end of life care training and there were systems in place to ensure that people approaching the end of life, and their relatives were aware of the care to be provided. Some people had made advanced decisions such as 'do not attempt to resuscitation' orders to ensure their last wishes were recorded.

Requires improvement

Is the service responsive?

Our findings

People told us that they received the care they needed. One person said: "The staff come quickly when I need them".

A visiting professional told us that they did not have any concerns about the care being provided at Temple Ewell. They said that staff responded to their advice and responded to people's needs.

Care needs assessments were carried out when people came to live at the service. There were pre admission assessments detailing people's individual needs, preferences and social needs. Families had been involved in the assessment and had signed to confirm they had agreed with the information. This was followed, on admission to the service, by a risk assessment, on which the care plan was based.

We looked at eight care plans. Some plans lacked individual detail. For example, for personal hygiene there was no involvement of the person to promote a degree of self-care by washing

their own hands or face, or explaining what help they needed to dress, or if they could manage a drink if it was correctly placed.

Staff were supporting people with their behaviour. However, this was through getting to know the person and staff handovers not by following written guidance. Guidance was needed to ensure that staff were supporting people consistently to minimise anxieties that could trigger an occurrence of negative behaviours. This was to ensure that care was person centred and that risks were identified and managed effectively.

One person had been assessed as needing oral hygiene but there was no care plan in place to make sure this was carried out on a regular basis. A care plan for prevention of pressure trauma stated "change position as frequently as necessary". The plan did not state how often this should happen, what re-positioning was required for the individual and how often this should take place, therefore, we could not be sure that this was being carried out effectively.

A person admitted had several wounds which had been recorded, photographed and an individual care plan had been written. The wound assessment chart reflected best practice and included details of the size of the wound, and how to treat the wound including the appropriate dressings. However, adhesive dressings were being used on very delicate fragile skin after skin tears which could damage the skin further. Also, the wound had bled during dressing change but the type of dressing had not been changed. The person was non-verbal and the care plan said to use non-verbal prompts to identify if there was any pain on dressing change but there was no description of these prompts.

Following a message from the doctor's surgery, one person was being barrier nursed (a system in place to reduce the risk of infection); however, there was a lack of information in the care plan to show why this was happening and what if any other action needed to be taken.

Staff told us that the nurses and team leaders updated the care plans but they did not have time to read them. They said that any information was discussed at hand over at the beginning of each shift. They told us that any concerns about people's care was discussed with the team leader or nurse and they would complete the care plan.

Care plans had not been updated since March 2015 therefore, staff did not have the current written guidance to follow to make sure people's needs were fully met.

The provider was not ensuring that person centred care and treatment was meeting the needs of people and plans had not all been regularly reviewed or updated. This is in breach of Regulation 9(1)(a)(b)(c), 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

People told us that there were some activities in the service, for example, games and bingo. Some people told us that they had played bingo but there were lots of times when nothing was happening and they were bored. One person said: "I like to be doing something or else I get bored". The deputy manager told us that there was an activity co-ordinator who visited the service two or three times a week. Activities included, paint/craft, chatting to people, and reminiscing sessions. There was information on the notice board to inform people of the planned activities and barbeques and creams teas had also been arranged. At the time of the inspection there was a singer entertaining some people in the lounge, however, many people remained in their rooms. There was no evidence to show that there were systems in place to make sure people were involved in the activities provided or had been spoken with to discuss what activities they may wish to participate

Requires improvement

Is the service responsive?

in. Some people choose to stay in their rooms due to their nursing care needs or preferences to watch their own television or listen to the radio. There was also a weekly newsletter detailing topical events and the news.

People we spoke with said that they did not have any concerns but would speak to staff if they had any problems.

The service had a complaints procedure on display in the entrance hall. A copy of this procedure was given to people when they came to live at the service. There was also a large print version available should people need this format. Complaints had been logged in a file and appropriate responses had been made by the service. Relatives told us that the service responded to complaints and they felt confident they were listened to and their issues were acted on. One relative told us that they had raised a minor issue and this was sorted out promptly and to their satisfaction.

Requires improvement

Is the service well-led?

Our findings

People and relatives were satisfied with the service. They told us that there was always a member of the management team or senior staff available when they needed them. The registered or deputy manager were on call when not on duty to make sure that staff could contact a manager if they needed support.

The service had a registered manager in place who was supported by a deputy manager, nursing, care staff and housekeeping staff. Staff told us that the management team were available and visible within the service. Staff and management meetings were held on a regular basis so that they had the opportunity to raise any concerns or discuss the service.

There had been recent changes in the nursing staff and the registered manager was recruiting to replace two nursing staff who had left the service. The registered and deputy manager were also responsible for most of the training in the service, which at times would take them away from the day to day running of the service. They had recently covered shifts in the service to cover the vacancies.

Although there were systems in place to regularly monitor the quality of service that was provided, such as medicine and care plan audits, the shortfalls had only recently been identified. The registered manager told us that the organisation had appointed a new Quality Manager who had visited the home recently and carried out a thorough check of the service. The report had highlighted the shortfalls within the service and an action plan was to be implemented to address these issues.

Records were not accurate and completed properly. Care plans did not show what person centred care was in place and did not always reflect the care being provided. There was a lack of documents being signed or completed including consent forms. One food and fluid chart dated 14/7/15 had only four entries and another chart dated 12/7/15 only had two drinks entered, when it was noted that the person should be having a drink/snack every two to three hours. An observation chart dated 27/7/2015 stated the person should be checked hourly but there were only two entries on the form, one at 08.30 and one at 10.30. One person had been seen by the speech and language team and it was recommended that their diet was changed from purred to soft diet, this had been implemented, however, this information was not reflected in the care plan.

The provider was not ensuring that person centred care and treatment was meeting the needs of people and care plans had not all been regularly reviewed or updated. This is in breach of Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Accidents and incidents had been recorded. They were analysed to ensure appropriate action was being taken to reduce the risk of further or similar occurrences.

People and relatives had been sent a quality survey to feedback about the service being provided in October 2014. A new survey was in process and responses had not been received at the time of the inspection. The staff survey carried out this year indicated that staff felt supported by their managers and worked well as a team. They said: “The nurses are really helpful”. “The managers do their best to run the service well even with the staff shortages”. “The managers or nurses are always there to answer any questions, they are approachable and listen to our concerns”.

There were no formal resident meetings but the deputy manager told us that they held regular coffee mornings where relatives were invited to have a chat and discuss the service; however, these meetings were not recorded to confirm what had been discussed or what had been suggested for improvements.

Nursing staff had received clinical supervision and there was a supervision system in place to make sure staff received supervision on a regular basis. Staff were clear about their roles and responsibilities. They were able to describe these well and were clear about reporting any concerns or issues to the nurse or management team. If any issues were identified they said these were dealt with quickly. Staff told us there was an open culture within the service and that the management team were approachable and they were available for advice at all times.

Staff understood the visions and values of the service, by treating people as they would want to be treated themselves. Respecting people’s individuality and beliefs

Requires improvement

Is the service well-led?

and ensuring privacy and dignity was upheld at all times. Staff said: “We really care, we make people feel welcome and safe”. “We treat people fairly, as an equal, and respect their human rights”.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people and supporting people with their behaviour. This is in breach of Regulation 12 (2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not always have sufficient numbers of staff on duty to meet the needs of the people. The provider was not ensuring that all staff received appropriate training to enable them to carry out the duties they are employed to perform. Regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider has not made sure that care and treatment of people was provided with the consent of the person and had not acted in accordance with the Mental Capacity Act 2005. Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider was not ensuring that person centred care and treatment was meeting the needs of people and care plans had not all been regularly reviewed or updated. Regulation 9(1)(a)(b)(c), 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems in place to quality assure the care being provided were not yet effective. Records were not completed properly or accurately. Regulation 17(1)(2) c)