Four Seasons Homes No.4 Limited

North Court Care Home

Inspection report

108 Northgate Street
Bury St Edmunds
Suffolk
IP33 1HS
Tel: 01284 763621
Website:www.fshc.co.uk

Date of inspection visit: 11 and 16 November 2015
Date of publication: 13/01/2016

Ratings

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

Overall summary

We carried out this comprehensive inspection on the 11 and 16 November 2015 and this was unannounced. The purpose of this inspection was to follow up on a number of safeguarding concerns received about people's experiences of poor care and people not being supported adequately with their nutrition and hydration which placed people at risk.

Following our previous inspection in February 2015 we asked the provider to take action to make improvements as we found evidence of concern that people were not sufficiently supported with their nutrition and hydration needs.

During this inspection the provider continued not to protect people from the risks associated with inadequate nutrition and hydration.

Summary of findings

Following the inspection we took action to restrict admissions until they had addressed the issues we identified. We also made a number of referrals to the adult safeguarding team which are currently being reviewed.

The service provides accommodation both residential and nursing care for up to 65 people who may or may not be living with dementia. The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our inspections we identified differential care practices on the two floors with no effective monitoring of staff practice. We saw there were enough staff to deliver the care but this was not always the case and there was a reliance on agency staff. New staff had been appointed but induction processes were poor and staff shadowing new staff did not have the necessary competence and skills.

Risks to people's health and safety were not fully documented and records were difficult to follow and people's needs were not fully understood by all staff.

The home was not clean and there was a high risk of cross contamination.

Medication practices were good but records did not always show medicines had been reviewed, or give enough information about individual medicines prescribed.

Staff recruitment was satisfactory but once staff were employed there was little support or monitoring of their practice. Staff training was not adequate and there was no assessment of staff competencies. Staff did not have the necessary skills and there was poor leadership.

People were not supported to eat and drink enough. Poor records and poor evaluation of records made it difficult to see how people were adequately supported with their eating and drinking.

Similarly people's health care needs were not always adequately recorded or documented.

Staff had not received or did not have sufficient understanding of the Mental Capacity Act 2015 and people were not adequately supported or consulted about their care needs.

We saw elements of caring practice but poor staff practice was left unchecked and staff were not clear about what the expectations were and their practices were not effectively monitored. There was no clear leadership or clear lines of accountability which resulted in variable staff practice. People were not always treated with respect or their right to choose respected.

Care plans were not written in line with people's individual preferences and wishes and records were difficult to navigate through. Staff did not use records effectively to help them know what people's needs were or how they could best meet them. People physical needs were met but there was not enough stimulation for people or recognition or promoting peoples' emotional and psychological well- being.

Complaints were not always recorded so we do not know if actions taken were always proportionate or helped improve the service.

Quality assurance and clinical governance arrangements were inadequate and did not demonstrate how they improved the service or took into account peoples experiences of care.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the full version of this report. The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to: • Ensure that providers found to be providing inadequate care significantly improve. • Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. • Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made

Summary of findings

such that there remains 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 the

Service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the

service by adopting our proposal to vary the provider's registration to remove this location or cancel the Provider's registration.

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?

Inadequate

The service was not safe.

There were not always enough staff with the right skills to meet people's assessed needs in a timely way.

Risks to people's safety were not effectively managed and staff did not have the right skills to deliver care in a safe way.

Medicines were given safety but records did not give enough information about people's needs or medicines were not always reviewed as required. Pain control was inadequate.

The home was not sufficiently clean and the risk of cross infection was high.

Staff recruitment processes were adequate but could be more robust.

Is the service effective?

Inadequate

The service was not effective.

People were not supported adequately to eat and drink enough for their needs and there was no clear evaluation of this.

People's health care needs were not fully assessed or met.

People were not adequately involved in decision making and the Mental Capacity Act 2015 was not fully understood by staff and nurses so we could not be assured it was implemented properly.

Staff did not have the necessary skills and arrangements for staff training and support were inadequate.

Is the service caring?

Requires improvement

The service was not always caring.

People did not have their dignity always upheld.

People were not fully involved in decisions about their care.

The standards of care provided in the home were not consistent from floor to floor from staff to staff which meant people received differential care experiences.

Is the service responsive?

Requires improvement

The service was not responsive.

People did not have their wishes and preferences taken into account which meant care was not person centred.

Summary of findings

Activities to keep people stimulated were provided but these were limited in scope.

Complaints were not always recorded so we could not see how they were acted upon.

Is the service well-led?

Inadequate 

The service was not well led.

There was a lack of clinical oversight or clear monitoring of staff practice. Staff felt well supported but we were unable to see how they were supported to carry out their job role effectively.

The manager was not well supported and we were unable to see how the homes own quality assurance systems helped to identify improvement and drive up the quality of the service.

Records were poor and they were not intuitive.

North Court Care 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.on the 16 November 2015. The inspection took place on the 11 and the 16 November 2015. The first was unannounced the second announced. The inspection was carried out by two inspectors on the first day and three the second.

During the inspection we observed care on both floors. We spoke with fourteen people using the service. We spoke with five relatives, nineteen staff including the manager, acting deputy, regional manager: domestic, catering staff, activity staff, care staff and nurses. We spoke with a number of visiting professionals. We looked at eight care plans and other records in relation to the management of the business including a medication audit. We also considered information we received prior, during and after the inspection in terms of notifications which are important events affecting the service which the provider is required to tell us about. We also looked at a number of safeguarding concerns.

Inadequate

Is the service safe?

Our findings

Staffing at this service was not always appropriate to the needs of people using the service and we were not confident that staff had the necessary skills and experience to deliver the care. During both our inspections additional staff had been brought in to support the home and the manager due to a number of concerns identified. Additional staff were considered necessary to bring about the required improvements. This meant that on the day of our inspection there were enough staff to deliver the care but there was a recognition that the use of agency staff had been wide spread and some staff reported staff sickness had affected the effective delivery of care. There were also a number of staff suspended following alleged poor practices which was having an impact on the staff team as a whole in terms of shift cover and further agency usage. The manager reported some long term sickness including the deputy manager which had meant that some areas of the work had not been effectively redeployed to other staff.

Two people we spoke with did not consider that there were enough staff (on first floor). One person said, "There's always a problem finding them." Another person told us, "Staff often seem non-existent and I don't see them for ages." Two staff we spoke with did not consider that there were enough staff for the dependency of people on the first floor. One member of staff said, "We could do with more staff. We tend to rush them and don't get the chance to chat. You're just in and out of their rooms." Staff told us that two thirds of the people on the first floor needed two staff to assist them to move and that half of them needed a member of staff to help them eat an adequate diet. On the dementia care unit on the ground floor staff said they worked at a team and usually this worked well. However staff told us earlier in the week there had been three agency staff on one floor. Staff told us agency staff did not always pull their weight and did not know people's needs so had to be supervised and shown everything. Permanent staff were picking up extra hours where they could but reported being tired. Some staff said they worked on their own floors and staffing levels were usually alright but there was a dip in September as staff left. However posts had been recruited to and there were new staff in post who were still on induction training. Staff told us when they were short staffed they could be rushed and it could take them a while to get round to everyone. They told us they started to assist people to bed after supper which was at five pm. This meant people potentially spent a-long time in bed and this was determined by staff rather than people using the service.

The home used an audit tool to determine how many staff it required to meet people's needs. We saw a copy of this and people's dependency levels were kept under review. However we were not assured that the data around people's dependency was accurate because care plans were not fully up to date. Staffing levels were said to be accurate and if anything the home was said to be overstaffed due to a number of vacancies whilst still maintaining the same staffing levels. It was difficult to assess staffing as there were more staff than the home said it needed during our inspection. However a number of staff had additional needs or were on induction which meant there were additional staff to support them.

We were not confident that all the staff had the necessary skills and experience to deliver care effectively. There was a heavy reliance on e-learning and there was no evidence that staff were assessed in the work place to ensure they were competent for the work they were employed to perform.

We found that the arrangements for staffing did not meet the needs of the people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive care and treatment in a safe way. Some staff who had started in the home earlier this year had not had any safeguarding training since they started. They had some previous experience in care work. However, they did not come across as confident in their knowledge of the different types of abuse that could occur or where they could report any suspected abuse apart from within the home. Staff told us they would report concerns to seniors or the manager depending on the seriousness of the concern, but staff failed to mention the role of external agencies.

We spoke with a person who had raised concerns with their social worker about being treated roughly. Another person also raised concerns with us. These concerns were either known or reported to the local safeguarding team so they could investigate. There were concerns about manual handling practices both in terms of training and practice.

Inadequate

Is the service safe?

One person needed a hoist to assist them to move. They told us, "I find hoisting very uncomfortable because the straps dig into you. I feel safe with some staff but others aren't very good at it." Two people told us that some of the staff were rough when providing their care. One person told us, "Some staff literally throw me about. They push me about unnecessarily. It wouldn't be so bad if they asked me first. They don't care how much they hurt you." Another person described the staff as, "A bit rough, they pull you about. They don't wait for you to lift your arm up they just grab it." We noted on the nursing floor there were at least 14 people in bed for most of the day. We were told that at least 14 people were requiring two staff for moving and handling. We concluded that most people who were immobile spend long periods of time in bed.

Risks to people's safety had been assessed and risk assessments were recorded for areas relating to pressure care, nutrition, hydration, falls and specific conditions relating to long term conditions. However we found gaps in people's records so could not see what steps had been taken to provide staff with guidance to minimise risk. Turning charts for example were not completed at regular intervals. People did not always have the correct pressure relieving equipment because it had not always been identified as part of their initial assessment. One person was very underweight as indicated by their body mass index. They were being cared for in bed. Their feet were down between the bed and the wall and there was no pillow between their knees to reduce the risk of pressure sores.

Some of the assessments in relation to the risk of developing pressure sores were not accurate and did not fully identify the potential risk. This might result in the risks not being fully addressed. Other risk assessments were contradictory. One person was identified as at high risk of choking in one record and at low risk in another. This could potentially lead to inconsistent care being provided. One person's weight had increased and their care plan stated that this could increase their risk of a pressure sore. They had capacity according to the Mental Capacity Act. However, there was no evidence that this risk had been discussed with them.

We found that the arrangements for safe care and treatment were not adequate and meant the risks to people were not fully mitigated and people received care in an unsafe way particularly in relation to their manual handling needs. This was a breach of Regulation 12 Safe care and treatment. Activities) Regulations 2014**.**

The standards of infection control were not sufficiently robust or maintained throughout the whole service. Staff were not consistently following procedures in line with national guidance on infection control. Relatives of a person who was in the home for a two week respite break had complained about poor care and poor staff hygiene practices. This had resulted in the person developing badly infected wounds and an infected gastrostomy feeding tube.

Surfaces in parts of the home were extremely dirty. A number of people's tables, used in the dining rooms and in their rooms, were heavily encrusted with food and drink. Staff were not getting the support they needed from the manager to address the lack of competence and concerns about the safe working practices of some domestic staff. One of the sluice rooms was completely disorganised with washing bowls and bedpans on the floor. Staff told us that some care staff did not wear gloves when emptying bedpans or wash their hands afterwards. When challenged by another member of staff, one carer had reportedly said that they did not have time to wash their hands.

The role of the night staff included washing sheets and towels that were soiled in the night and cleaning the communal areas. Staff told us that none of this was done. Laundry staff told us that care staff usually used the appropriate bags for soiled laundry to minimise possible cross infection. However, they said that some care staff did not always follow infection control procedures and bag soiled laundry appropriately. Laundry staff were sorting washing out of doors and sometimes in the rain, because the laundry room had insufficient room. They told us that the washing machines were not large enough for the volume of laundry they had to deal with. They had previously been told that new industrial machines and an additional dryer would be ordered but this had not happened. The washing machines had been out of order over the weekend, which resulted in a massive backlog of washing. The housekeeper said that they had not been told that two people were changing rooms over the weekend. This meant their new rooms were not 'deep cleaned' before people moved in and they were concerned about the potential for cross infection. Staff we spoke with had not received recent infection control training.

Inadequate

Is the service safe?

We found that the arrangements for infection control and cleanliness of the service fell short of the expected standard. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines safely but we identified a number of concerns around the reviewing of people's medicines particularly pain relief and records. Two people told us they were happy with the way the nurses managed their medicines. One person seemed very depressed. They told us, "I don't want to live. I can't move and I'm stuck here day after day." They were on a low dose of an antidepressant but there was no evidence that staff had asked the GP to review their medication in light of their continued depression. Care plans for medication were of a varying quality. Some listed people's medical conditions and their medication. However, they did not mention the possible side effects, whether they were tolerating the medicine or whether the current dose of their medication was adequately treating their medical condition. Another care plan on medication mentioned a list of possible side effects but did not link them to the person and their tolerance of the medicines. One person told us that they regularly had considerable pain. However, their medication care plan did not mention their pain control or when they had last had a review of their pain killers. The recording of topical medicines was not consistent. One record demonstrated that a person did not receive an application of their topical creams on some days and on other days received the application two or three times. Pain relief for people was poorly managed and people did not have an adequate assessment of their pain tolerance.

We carried out a medication audit on one floor and medicines were given safely. The storage, administration and disposal of medicines were satisfactory. Medication procedures to guide staff were clear and well executed. Nurses spoken with were knowledgeable regarding the safe administration of people's medicines. There were no observed omissions on medication recording sheets. The nurse offered people prescribed when necessary medicines and enquired after people's welfare. Controlled medicines were stored correctly and appropriate checks made.

New staff were subject to recruitment checks to ensure they were suitable. Recruitment records were satisfactory and the home used agency staff from one main agency and had a proforma for agency staff which showed essential recruitment checks had been carried out and staff had the basic training required. New staff were not employed until satisfactory checks were in place but information from references were not robust and we could not see that gaps in employment or areas of concern were thoroughly explored at interview stage. No staff started without proof of identity, work permit and employment history. A criminal record check was also carried out to ensure staff were not unsuitable to work with older people.

Inadequate

Is the service effective?

Our findings

People were not adequately hydrated or protected from the risks of malnutrition because the records did not tell us how this was adequately monitored and evidence of support provided recorded or evaluated.

At the last inspection on the 3 February 2015 we found the provider had failed to protect people from the risks associated with inadequate nutrition and hydration. The provider sent us an action plan on the 20 May 2015 telling us what action they would take to ensure compliance. We found at the inspection in November 2015 a number of staff had undergone additional training on nutrition and hydration and had been identified as nutritional champions. Their role was to ensure people's weights were effectively monitored and other staff knew what actions to take if there were concerns about people's nutrition. They were new to this role and had a good understanding of their role and felt they were having an impact. They told us people at risk of losing weight or of dehydration were regularly monitored and had static weights.

We looked at a sample of records, (8) to see how people were supported with their nutrition and hydration. The records did not support the fact that people always received enough to eat and drink, where people had refused a meal we could not see if an alternative was offered. There was no expected target referenced as to the quantity or frequency of fluids and the totals were not calculated. Some records did not include snacks or supper which meant people were going for long periods of time with nothing recorded. It was not clear from the records what action was taken when people did not drink enough, records did not show us that totals were added up or there was a clear protocol of actions.

We saw a person with dementia who was very active which would have an impact on their calorie intake and weight. Their record included a blank malnutrition universal screening tool and some contradictory information about how frequently they should be weighted. Their care plan stated both weekly/monthly weights and there were two weight charts in place with weights recorded that did not fully correspond with each other. We saw that they had been referred to the dietician but any initial weight gain had since been lost so we could not see if interventions were helping the person or if they needed further review. There was not always a monthly update recorded. One record told us they were diabetic, another told us they were on a normal diet which meant we could not be assured staff would know what this persons needs were. Staff spoken with who were familiar with the unit were able to tell us. However agency staff had nothing to guide them in terms of what each person's main needs were. They had to rely on the care plans which were inaccurate.

Another person had been diagnosed with a urine infection. Care staff had been asked to encourage them to drink more and they had been asked to complete a fluid balance chart. The chart stated that the daily total should be 25mls for every kg of weight. The target amount was not recorded on the chart to make it clear to staff what they should be aiming for. According to their weight at the time of our inspection the target should have been 1365mls in every 24 hours. However, over a period of four days their total intake was 365mls on one day, 590mls on two days and 1200mls on one day. The daily amounts had not been added up and there was no evidence that the nurses were monitoring and responded to any inadequate intake of fluid.

We met with catering staff who were knowledgeable about people's dietary needs but learnt that one chef was off sick so not all staff were as knowledgeable not had they had training essential to their role. Kitchen staff said finger food was available including crisps, sandwiches and home-made milk shakes.

We spoke with a family member who had previously raised concerns about their relative's weight loss and the apparent lack of action taken by the provider. They told us that since raising concerns, 'the home was on top of things.' They said their family member was maintaining weight and their needs were being met. However their confidence with the service was low. They told us they purchased and brought in their own food/snacks for their family member. Because the quality and quantity of food was poor.

We observed lunch on more than one occasion on the two separate units; one was predominantly for people with dementia, the other for people with nursing needs. People's experiences were variable according to the unit they were on. On the dementia care there were a number of visitors who helped people with their meals. There were enough staff on hand to support people at their pace. Staff were observed to be polite and caring, treating people with dignity and respect. We saw the environment was a little chaotic with most people sat in their day chairs and only a few people were assisted to the table. Staff offered people

choices and we saw little wastage. However, staff did not offer choices which were meaningful for everyone. For example pictorial menus were not used although the chef said these were available. Staff told us that there was no adapted cutlery to help people with limited dexterity eat independently for as long as possible

On the first floor most people ate in their rooms where they had been all morning. It was not clear if it was people's choice to do so. The atmosphere in the main dining room was subdued. Staff interaction was minimal and people were not given appropriate menu choices. However, when a person appeared not to like something staff offered alternatives. We were concerned that staff communicated across the room with people rather than going to them and maintaining contact at eye level. Staff told us that half the people living on the first floor needed staff assistance to eat an adequate diet. Staff told us that they received nourishing food and drinks from the kitchen to supplement people's diets if they were losing weight. Staff told us that they received milk shakes mid-morning and mid-afternoon along with biscuits or cake. They also had access to snacks such as yoghurts, crisps and bananas. However, we did not see evidence that they were being offered to people on a regular basis. Staff encouraged one person to eat a pureed diet. Their pace of eating was slow but staff were patient and assisted them to eat for about 45 minutes. However, their meal was on a plate and was completely cold about half way through their meal. The home did not have any heated plates to keep meals more appetising over a longer period of time. People on the first floor waited a very long time for their meals. One person told us, "The food's not too bad." Another person described the lunch as "revolting" and "tasteless". They only ate a couple of mouthfuls and they asked staff to take their plate away after about half an hour. The carer who removed it did not ask if they wanted anything else. They were offered a pudding ten minutes later. When they refused they were asked if they wanted an alternative and chose a cheese sandwich. They told us that they did not usually get offered an alternative, "today was unusual". They told us about the food they liked but none of this was documented in their care plan. Some people received a poor dining room experience and there were no audits, or observations of this completed by the manager specifically to see how this aspect of care could be improved upon.

We found a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**.**

People's health care needs were not met in a satisfactory way. Body maps were used to record any changes to people's skin. We saw in some records that people had unexplained bruising. This was clearly documented with photographic evidence. It was less clear as to how people had acquired the bruising. One person had extensive bruising due to a ring becoming too tight but it was unclear from the records how long this person's finger had been swollen before the home took necessary action. We saw for another person that they had a bruised, infected toe but not what had happened in terms of healing and if this was still an area of concern.

Both nurses and care workers were not ensuring adequate pain relief for people and were not sufficiently knowledgeable to assess this or request an assessment by a health professional to assess. We observed people crying out in pain with no investigation of this. We asked staff if the person calling out had been referred to the GP or if the family had been asked why the person might be calling out. Staff were not able to tell us and there was nothing recorded. Pain assessments gave very limited detail and it was not clear how pain was effectively managed particularly where people might not clearly be able to articulate their pain.

One person told us that they saw the GP and attended hospital appointments when they needed to. They said, "They usually look after me fairly well." The records showed that they had recently received treatment for a chest infection. Health care professionals said staff made timely referrals to their service. However we saw gaps in people's health care records. One person had seen the chiropodist regularly in 2014 but there was nothing recorded for 2015.

It was difficult to establish if people were supported effectively to make decisions about their care and welfare. Mental capacity assessments were completed where there was a question about a person's capacity. The rationale for lack of capacity was limited. We could not see how people were routinely involved in decision making as this was not always recorded. Relatives told us that they were not routinely asked for their feedback as part of an annual review or resident/relative meetings. Staff gave us an example of a person who fell and for their safety were placed in a chair which tilted back, this inhibited them and

Is the service effective?

meant they were unlawfully restrained. They were also unable to feed themselves because of their seating position. This has since been rectified however the practice was abusive and unnecessary.

Mental capacity assessments had been carried out and demonstrated that some people had capacity to make day to day decisions about their food and their personal care but could not always make more complicated decisions about medical care or any financial decisions. However, the nurses did not fully understand their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) as they only considered that doctors and the person's next of kin could make best interests decisions. They made no mention of whether the next of kin had Lasting Power of Attorney for either the person's finances or their health. There was also no mention of nurses and care staff making appropriate best interests decisions on a day to day basis. A carer we spoke with did not have any understanding of the MCA People and their relatives where appropriate, had not always been consulted about decisions regarding their care and treatment at the end of their lives (Do Not Attempt Resuscitation.)

We found that the arrangements for gaining people's consent or acting in people's best interest where they lacked capacity were not robust. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**.**

Staff did not have the necessary skills and competencies for their role. Staff training records were not forwarded to us as requested. Staff spoken with had completed most of the required training but had done most of this through e-learning. Staff told us manual handling training was being updated and formal assessments of their competence were being completed. This training had lapsed for some staff. New staff were not permitted to support people with their manual handling needs until they had been assessed as competent in this area of practice. However there was no evidence that staff were adequately supported in terms of their learning, development and training needs. Staff did not receive an annual review of their performance; they did not receive regular supervision or observation of practice. Staff had not generally undertaken training relevant to the needs of people using the service such as Parkinson's disease and not all staff had completed the core training required in adult social care. Staff did not have the opportunity to regularly discuss areas of practice.

One member of staff told us that their induction was shadowing a more experienced member of staff for two days but that it did not include any training. Staff told us that they had not had any recent training apart from moving and handling. They told us that previous training had usually been e-learning. There was no classroom based training, no observations of care or work based practices or any supervision. This resulted in some staff not feeling equipped and supported to carry out their roles. One member of staff told us, "I've had no practical guidance and no face to face training." One of the domestic staff told us that they occasionally assisted people to eat their meals. However, they had not received any recent care related training. Induction records for new staff were not made available to us and there was no evidence of monitoring staff as part of their probationary period. A number of staff disciplinary were being conducted but due to poor monitoring of staff it was difficult to see if there were previous performance issues with these staff or if they were isolated incidents.

We found that the arrangements for supporting and training staff to ensure they had the necessary skills and competence were not in place. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**.**

Requires improvement

Is the service caring?

Our findings

The observations of care practice were mixed depending on which floor we were observing. We found some very positive interactions on the dementia care floor with people being acknowledged and staff treating people with respect. Caring interactions were observed through the day and people laughed and joked with staff. Staff were sufficiently familiar with people's relatives who were made welcome. Most people could not tell us about their experiences and there was little recorded about how people wished to be cared for. Regular staff told us how people could be 'aggressive' and what they could do to calm the person down and why people became distressed. However, this was not recorded as part of the persons care. Regular staff told us they were concerned if agency staff could work with people effectively or know how to manage their behaviours. Staff told us people liked consistency and not to be reliant on agency staff. We saw that most of the day was spend delivering care and very little time was spend on providing meaningful activity for people.

We spoke with people on the nursing floor. One person told us, "The staff are not too bad, some are better than others. Sometimes the staff treat me as if I'm an idiot. I get a lot of pain. It's really bad. Even little movements hurt. But some staff get me to do things when I'm in pain." Another person said, "The staff are alright if they're in the mood."

Through our observations we noted people spend prolonged periods of time in bed with little to stimulate them. Opportunities for positive social interaction were missed such as lunch time when staff did not always acknowledge people appropriately or investigate reasons for people calling out. Some people were unable to use their call bells so calling out could have been a way of alerting staff that they needed attention. One person who was very articulate did not have a call bell. They told us, "I wait until they come. It would be nice if I could reach the (call bell) button on the wall."

A few people had long and in some cases very dirty fingernails. Two months prior to our inspection a chiropodist had made a record requesting that staff cut a person's fingernails as they were very long. This person had very dirty fingernails on the day of our inspection. We discussed this with the nurse on duty and they said that this would be addressed immediately. Another person had long and dirty fingernails on the first day of our inspection. This was reported to the staff. On the second day their nails had been cut but they were still very dirty. This did not uphold these people's dignity. One person told us that they sometimes needed to use their glasses for reading. However, they were so thickly covered with spilt milky drinks and dust that it would not have been possible to see out of them.

One person's continence care plan stated in one place that they were doubly incontinent but in another that they could "ask for the bedpan". They told us, "When I ask to go to the toilet they say go in your pad." This did not uphold the person's dignity. A family member gave us another example when staff refused to change their relatives pad because they had recently changed them. This person was soiled. This was referred to the safe guarding team.

One person told us that a member of staff occasionally took them out. They said, "I adore going in to town but it's been a while since I last went out."

There was poor evidence of how people were consulted about their care needs or how their feedback shaped and improved the care they were provided. Relatives told us they were kept informed about changes to their family members needs but said in some instances they had to 'micro manage' the service. Evidence of resident/relative meetings was minimal.

We found that people were not always treated with respect or their dignity and independence promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

People did not receive care which was centred around their expressed needs, wishes and care preferences; neither did staff always act in their best interest. We were unable to establish from people's care plans what their main needs were because care plans were unnecessarily complex with contradictory information. When a person's needs had changed records were not archived so there was often two sets of records and care plans gave different information. The example given earlier was having two sets of weight records one monthly one weekly and different information about the person dietary needs, 'normal diet', 'diabetic diet'. Records included care plans for an unidentified need such as a 'breathing/ care plan where there were no concerns about the persons breathing. Gaps in people's records meant we could not see if people's needs were reviewed sufficiently or if staff took into account changes in people's needs.

Records did not include a clear plan to guide staff in responding to the needs of people during the night time period. This had the potential to put people at risk as there was a high use of agency staff at night who might not be so familiar with the person's needs. It would have been extremely difficult for new or agency staff to find the information they needed to in order to give person centred care. Following the first day of our inspection the manager had devised a summary of people's nutrition and moving and handling needs for agency staff. However, there was no information on people's preferences, main medical conditions or details of any current health concerns, infections or pressure sores. There were no life histories in people's folders to give staff an insight into people's background and interests. The care plans were not centred on the needs of the individual. Care staff told us that the care plans were the responsibility of the nurses and that they did not have time to look at them. Only one carer told us that they had looked at people's care plan folders on a couple of occasions.

Care folders contained at least 16 care plans covering the following areas: rights and consent, medication, mobility, manual handling, falls risk assessment, best interest checklist, use of bedrails, nutrition, incontinence, personal hygiene, sexuality, skin integrity, psychological and emotional needs, sleep, infection control, communication, human behaviour and end of life care. All of the care plans were generic in content and were largely a series of tick boxes. There was no evidence of any personalised or individualised content which related to any preferences or choice for the person. There was no evidence that the person or relatives or friends had been involved in the development of the care plans. We spoke with one person who told us how important their family dog had been to them. However there was no reference to this at all in the persons care plan or preferences folder.

Care plans did not include people's care preferences or choices of care. We talked to staff about how they met people's needs and their approach to care. This seemed to be based largely on staffing levels and any known requests from relatives. For example if a relative had requested their family member was assisted out of bed at a certain time then this was done but for other people they might still be in bed just before lunch time and a lot of people were in bed throughout the day without a clear rationale for this. Staff complained,' the night staff get the easy ones up."

The manager told us a document called, 'Connecting with your community, my choice, and' my preferences.' Was a key document which recorded people's main needs and preferences of care However we found these forms were either in complete or blank. For one person we case-tracked recent events at the home had increased this person's risk and they were subject to a safeguarding investigation which was substantiated. This person had advanced dementia but there was no information in place in terms of their needs, preferences and personal history. This person had behaviours which could compromise theirs or others safety. However there was no evidence that staff had tried to understand this person's distress or root cause of their behaviours. This meant behaviour was managed rather than pre-empting causes for this person's distress so that staff could support them appropriately. The persons care plan told us nothing in terms of this persons preferences, if they minded male/or female carers. It referred to challenging behaviour but not in what context/ situation or what would reduce unwanted behaviours. The type of dementia they had resulted in hallucinations but there was no a mental health care plan or strategies for reducing the persons distress. Staff supporting people with dementia had basic dementia training which was not sufficient in terms of providing good, holistic care.

Where people's preferences were recorded there was no evidence these were upheld. For instance one person's care

Requires improvement

Is the service responsive?

plan stated that they preferred to eat in their room "listening to classical music". They were sitting in the dining room on the day of inspection. They told us, "Staff insisted I came into the dining room. I don't like being here with people I can't talk to." A number of people had advanced dementia and could no longer speak to staff. However, there was often no record of whether the person had any non-verbal communication that might help staff to provide more personalised and responsive care.

During our first visit in response to the shortfalls we identified additional support had been put in place to support the manager and ensure all care plans were updated. Nurses told us they were just starting to review care plans. The manager told us 15 care plans had been reviewed downstairs and eight upstairs. The also told us there was a resident of the day on each floor which meant everyone needs were reviewed at least monthly.

Some staff had handwriting that was nearly illegible. This on occasions made it difficult to assess people's changing needs.

We found that people did not receive person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014.)

Social activities were arranged and displayed on the unit. However there was only one person employed to arrange and facilitate activities and they split their time between two units and were employed for thirty hours per week. We saw some small group activity and one to one support for people but this did not meet the needs of most people's social needs and we saw a lot of people were unoccupied for large parts of the day unless they had family visiting. Staff were expected to facilitate activities and staff told us they did this when they had time. One example was reading with people. We also saw a film was put on for people to enjoy but due to people's cognitive impairment only very few people were observed as watching the film or participating in this planned activity.

There was a clear complaints procedure and the manager told us they were proactive in dealing with people's concerns and talking to families where there were shortfalls of care. Complaints were logged and could not be signed off until appropriate actions had been taken and signed off by the manager and regional manager. This meant there was a quality assurance process was in place. However we had been told about care concerns and although the manager acknowledged concerns had been raised these had been logged so could not see what actions the manager had taken and if action was always effective.

Inadequate

Is the service well-led?

Our findings

The service was not well managed because we identified poor outcomes for people using the service stemming from the provider's lack of action to provide sufficient assessment and evaluation of care and monitoring of care being delivered by staff who neither had the skills or competence to meet people's assessed needs. The manager told us that things were difficult in the absence of a deputy manager who had been on long term sick. The home had recently appointed a deputy manager from another service but this was only for a period of two weeks and the person was then being replaced by a regional manager. Nursing staff did not have clear lines of responsibility or areas they were accountable for. Although the service supported people with mental health issues there were no nurses employed with a mental health qualification.

The feedback we got about the manager from his staff was positive. Staff said he was approachable and listened to them. They said he consulted with staff and acted upon their concerns and feedback. One member of staff told us that the manager tried really hard but needed support because it was a big home. Most staff told us morale was good and lots of new staff had given the home the boost it needed. Staff acknowledged that shortages of staff had impacted on the care and they had not received formal support for quite a while. Records supported this, staff training, and support was inadequate and there were no assessments of competence of staff practices other than for medication and manual handling.

One of the care staff told us, "If you have a problem you can talk to the manager." "The best thing about the home is the staff friendliness."

Most relatives spoken with felt the care was good and staff kept them informed of any changes in their relative's needs. However several relatives felt they had to keep raising concerns and monitoring what action was taken to ensure improvements were sustained.

The nurses on the first floor were not monitoring the standards of care or managing the care staff. This resulted in variable standards of care. Care was task orientated. There was no visible nurse leadership. Care staff did not know if there were any set quality standards or expectations for their work. We heard one member of staff saying, "We're doing a pad round." And we found other language used by staff to be disrespectful and indicated a task focussed approach to care.

Over the two months prior to our inspection there had been three serious complaints raised by relatives of people in the home. These included concerns about weight loss due to inadequate support for people to meet their nutritional and hydration needs. One example was of severe dehydration discovered for one person on their admission to hospital and poor personal care and infection control leading to the infection and breakdown of one person's skin. We also received information of concern about another person who had raised concerns about their care and treatment and this was being investigated by the local safeguarding authority.

The senior nurse on shift on the first floor was from the agency. They did not know how many people there were on the nursing floor, the names of people, their care needs or diagnosis. They were unsure how many care staff were working the shift. This gave us concerns to how well temporary staff were inducted to shift and about the continuity of care for people using the service.

Staff reported frustration with the night staff and there was a clear sense that the staff team were not working together for the benefit of people using the service. Staff worked on designated floors and reported different experiences on each floor with more cohesiveness reported on the ground floor. Staff said that often work was task orientated and that they care for more people in bed when busy or short of staff.

Staff complained that night staff did not help sufficiently in getting people out of bed and often the laundry was not done. A member of staff told us, "I would like the night staff to put the hoists on charge. It's a regular problem. It's very frustrating." There were concerns both around the catering team and the cleaning staff and a lack of support and supervision of staff.

The home had a quality assurance system which had been trialled in other homes and with some degree of reported success. IPADs were used and available at reception for people/visitors to give their feedback either anonymously or as part of the overarching quality assurance system where feedback was routinely sought from people, each question asked might give rise to additional questions to

Inadequate

Is the service well-led?

ascertain how well the persons needs were being met and if they were satisfied with their care. Up to 90 questions could be asked and feedback was evaluated to see where if any the gaps were. The manager told us they reviewed one person each week on each floor. We asked how they captured people's experiences when they were unable to formally answer questions. They told us questions were intuitive and would prepopulate other questions and this would not be used in isolation. They told us they would also speak with family, staff and look at records. However we were concerned that this in itself was not effective in identifying where the service was not meeting people's needs. Through our observations we were able to identify areas of concerns and in the absence of audits on key areas of practice such as an activities audit, and dining room audits it was difficult to see how people's experiences were measured in a meaningful way to the person. The manager said he did do a daily walk around and would go on shift on a night for example but did not evidence what he did during these visits. We also found when concerns were raised these were not always documented to show what actions were taken.

Surveys were also collected and action plans devised as a result of feedback showing how concerns where identified would be addressed. Actions were signed off by the regional manager. The home were working towards dementia accreditation and was being audited by internal verifiers as part of this process. We found that improvements to the environments had been created but staff support around the provision of person centred dementia care was lacking.

Records for people were poor and did not show effective planning and evaluation of people's needs. Neither did they demonstrate that care was provided around individual need.

We found that people did not receive high standards of care and clinical governance was poor. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**.**

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.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services and others were not always supported by sufficient numbers of staff who had the necessary support and skills to be able to deliver the care effectively. Regulation 18 (1) (2) (a) (c)

The enforcement action we took:
We issued an urgent Notice of Decision to vary the conditions of the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others did not always receive safe care and treatment. Not all was done to mitigate risks to people and staff carrying out care did not have the skills, competence and experience to do so safely. Regulation 12 (1) (2) (a) (b) (c)

The enforcement action we took:
We issued an urgent Notice of Decision to vary the conditions of the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The premises were not clean or suitable for use. Regulation 15 (1) (a)

The enforcement action we took:
We issued an urgent Notice of Decision to vary the conditions of the provider's registration.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were not adequately supported with their nutritional and hydration needs and there was inadequate monitoring of this. Regulation 14 (2) (b)

The enforcement action we took:
We issued an urgent? Notice of Decision to vary the conditions of the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People did not receive care based around their assessed needs and wishes and records were ambiguous. Regulation 9 (a) (b) (c)

The enforcement action we took:
We issued an urgent? Notice of Decision to vary the conditions of the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People using the service were not always treated with dignity and, or respect or their independence upheld. People were not fully supported to be involved in their care. Regulation 10 (a) (b)

The enforcement action we took:
We issued an urgent Notice of Decision to vary the conditions of the provider's registration.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Systems established to measure, monitor and improve the standards of care delivered to people were ineffective and the care that people received was not always effective in mitigating risk and promoting people's health, well- being and safety.

Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

We issued an urgent Notice of Decision to vary the conditions of the provider's registration.