Rushcliffe Care Limited

Normanton Village View Nursing Home

Inspection report

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Date of inspection visit:
04 September 2017
05 September 2017

Date of publication:
21 February 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 4 and 5 September 2017 and the first day was unannounced.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with Care Quality Commission (CQC) about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks.

The provider is registered to provide accommodation for up to 72 older people living with or without dementia; the home covered two floors and was split into four separate units, two on each floor. There were 55 people using the service at the time of our inspection.

At our last inspection on 7 June 2016, we asked the provider to take action to make improvements in the area of consent. We received an action plan setting out when the provider would be compliant with the regulation. At this inspection we found more work was required in this area and the regulation was not complied with.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

A registered manager was registered with the CQC; however, they had recently stopped working at the service. A representative of the provider was present both days of the inspection and told us they would be applying to register as manager for the service. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks were not always managed so people were protected from avoidable harm. Staff did not always follow safe medicines management and infection control practices.

Sufficient staff were not always on duty to meet people's needs. Staff understood their duty to protect people from the risk of abuse but did not always know how to report any concerns to external organisations.

Staff were recruited through safe recruitment practices.

Staff felt supported but did not always receive appropriate induction, training and supervision. People's rights were not fully protected under the Mental Capacity Act 2005.

People told us they received sufficient to eat and drink but the mealtime experience required improvement. Adaptations could be made to the design of the home to better support people living with dementia.

External professionals were involved in people's care as appropriate.

Staff did not always respect people's privacy and dignity. Some staff were kind, however most staff were task orientated. People and their relatives were not involved in decisions about their care. Advocacy information was not available to people.

People received care that promoted their independence. People could receive visitors without unnecessary restriction.

People did not always receive personalised care that was responsive to their needs. Activities needed improvement. Care records did not contain sufficient information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints. Complaints were responded to appropriately.

Systems were in place to monitor and improve the quality of the service provided, however, they were not fully effective. As a result the provider and registered manager were not fully meeting their regulatory requirements.

People and their relatives had some opportunities to be involved in the development of the service but could be involved further and their feedback was not always acted upon by staff.

Staff told us they would be confident raising concerns with the management team and appropriate action would be taken.

We found six 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.

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.

Risks were not always managed so people were protected from avoidable harm.

Staff did not always follow safe medicines management and infection control practices.

Sufficient staff were not always on duty to meet people's needs.

Staff understood their duty to protect people from the risk of abuse but did not always know how to report any concerns to external organisations.

Staff were recruited through safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff felt supported but did not always receive appropriate induction, training and supervision.

People's rights were not fully protected under the Mental Capacity Act 2005.

People told us they received sufficient to eat and drink but the mealtime experience required improvement.

Adaptations could be made to the design of the home to better support people living with dementia.

External professionals were involved in people's care as appropriate.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always respect people's privacy and dignity.

Some staff were kind, however most staff were task orientated.

People and their relatives were not involved in decisions about their care. Advocacy information was not available to people.

People received care that promoted their independence. People could receive visitors without unnecessary restriction.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their needs. Activities needed improvement.

Care records did not contain sufficient information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints. Complaints were responded to appropriately.

Is the service well-led?

Inadequate

The service was not consistently well-led.

Systems were in place to monitor and improve the quality of the service provided, however, they were not fully effective. As a result the provider and registered manager were not fully meeting their regulatory requirements.

People and their relatives had some opportunities to be involved in the development of the service but could be involved further and their feedback was not always acted upon by staff.

Staff told us they would be confident raising concerns with the management team and appropriate action would be taken.

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Detailed findings

Background to this inspection

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

This inspection took place on 4 and 5 September 2017 and the first day was unannounced.

The inspection team consisted of two inspectors, a specialist nursing advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete 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 reviewed other information we held about the service, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service and Healthwatch Derby to obtain their views about the care provided by the service. We used this information to plan this inspection.

During the inspection we observed care and spoke with six people who used the service, four visiting relatives or friends, two visiting social care professionals, two reception staff, a domestic staff member, a laundry staff member, the activities coordinator, a maintenance staff member, three senior care staff, the cook supervisor, two care assistants, a nurse, the head of human resources, a compliance officer, the quality and compliance lead and senior representatives of the provider.

We looked at the relevant parts of five people's care records, three staff files and other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

Risks were not always safely managed by staff. Views were mixed on whether staff supported people to move safely. A person said, "I transfer to the shower chair with staff support and staff shower me. I explain to new staff about my fragile skin and guide them. Staff are gentle when washing me and will dry my skin by dabbing it." However, a visitor said, "Some staff are great and use the hoist. However, I have seen staff using underarm lifts and picking people up using their trouser waists. I have raised this with the home but got no response." A visitor also told us staff providing one to one care to a person at risk of falls did not always sit close enough to that person to minimise the risk.

We observed people were assisted to move safely when staff used equipment to move people; however, we saw staff did not always walk at a safe pace when supporting people who had difficulty walking. Some staff tended to walk ahead of people they were supporting instead of walking alongside them. We also saw staff providing one to one care did not always stay close enough to people to minimise their risk of falling. This placed people at risk of avoidable harm.

Risk assessments were completed to assess risks to people's health and safety. Individual risk assessments were completed for risks such as falls, nutrition, pressure ulcers and moving and handling. However, when bedrails were used to prevent people falling out of bed, risk assessments were not always completed to ensure they could be used safely. This meant people might be placed at risk of avoidable harm if bedrails were not used appropriately.

A nutritional risk assessment had been completed for a person and a dietitian had reviewed the person's nutritional needs. The dietitian had recommended staff weigh the person weekly or complete another measurement which provides an estimation of their weight if it was not possible to weigh them, again on a weekly basis. We saw this had not taken place in the four weeks leading up to our inspection visit. This meant staff were not monitoring this person's weight to minimise their nutritional risks.

A visitor said, "Staff check [my family member] every half an hour when I'm here. When he sits on his chair they come and reposition him on his cushions regularly." Pressure-relieving mattresses were in place for people at high risk of developing pressure ulcers but mattresses were not always set correctly to minimise the risk of skin damage. We saw a pressure cushion was not in place for a person who required it. Records were also not fully completed to show a person received support to change their position to minimise the risk of skin damage in line with their assessed needs as set out in their care plans. This placed people at risk of avoidable harm.

Following the death of a person from choking, management had put processes in place in order to ensure the risks of this re-occurring were addressed. We saw staff on the unit where the person had died were taking correct actions in line with these processes. However, we found food left unattended on another unit which put people at risk of avoidable harm.

We saw checks of the equipment and premises were taking place. However, a staff member told us some of

the emergency lighting bulbs required replacing following a recent check. We also saw parts of the premises and environment were not safe as staff were not always following safe working practices which included leaving potentially harmful substances unattended. This placed people at risk of avoidable harm.

We observed the administration of medicines on the first day of our visit and saw staff made the required checks and stayed with people until they had taken their medicines. However, we saw a staff member did not support one person to use their inhaler effectively. On the second day of our visit we observed a nurse did not safely administer medicines, giving them to a care staff member to give to people and did not witness medicines being given while signing to say they had. On the same unit, we found two tablets on the floor and drew them to the attention of the staff member who did not know whose they were. We saw there was no longer anyone sitting on the chair they were found under.

When a person was reluctant to take their medicines, the staff member explained why they were necessary and when this was not successful, they left the person for a few minutes and tried again. We saw another person was frequently refusing to take their medicines. We discussed this with staff and they showed us evidence that the person's family doctor was contacted to review the person and their medicines. We saw a significant number of people were given their medicines covertly. This is when medicines are disguised in food or drink and given to people. When this was the case their family doctor was involved in the decision and there was a record of discussion with the person's family. However, there was no record of involvement of a pharmacist to ensure medicines were safe to be given covertly.

Medicines administration records (MARs) did not contain information to aid safe administration. There were no photographs of each person, the section to record allergies was not completed and there was no indication of people's preferences for taking their medicines. In addition, care plans did not contain information on people's preferences in relation to taking their medicines. When medicines were handwritten on the MAR, they should be checked and signed by a second person to ensure accuracy of transcription. This was not evident in the MARs we reviewed. These issues meant there was an increased risk of medicines errors occurring and people's preferences not being catered for.

We found gaps in the administration record for five people on a particular day. We spoke with a nurse and they identified a particular issue which had occurred on that day which may have led to medicines being missed. We checked the medicines for each of the people and found in the case of three people the medicines were given but not signed for. For one person, the nurse told us the medicine had been withheld on that occasion due to the condition of the person. However, when we checked another medicine we found the number of tablets remaining, indicated that not only had the medicine not been given on the occasion when the record was not signed, but there were additional tablets remaining which indicated the medicine was not given on three occasions when it had been signed as being administered.

We also found a person who was receiving a medicine which was given in different amounts on different days of the week, had received the wrong dose on one day over the previous week and on some other days the record of the amount given had been changed making it difficult to be sure whether the correct dose was given. This placed the person at risk of avoidable harm.

When medicines were prescribed to be given only when required, protocols were not in place to provide the additional information to ensure they were given consistently and safely. Liquid medicines and topical creams and ointments were not always labelled with a date of opening to ensure they were used within the appropriate timescale and remained effective. This placed people at risk of avoidable harm.

Medicines were stored in locked cupboards, trolleys and refrigerators within locked rooms. The temperature

of the room and refrigerators were recorded daily and were within acceptable limits, however, maximum/minimum temperatures were not recorded for the refrigerators. This meant staff were not effectively monitoring temperatures to ensure medicines were stored at correct temperatures to remain effective at all times.

A visitor said, "Cleanliness in the home is okay. The laundry keeps [my family member's] clothes in a good state." During our inspection we looked at some bedrooms, all toilets and shower rooms and communal areas and found some parts of the home were not clean, some equipment requiring replacing in order to be effectively cleaned and staff did not always follow safe infection control practices.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views of staffing levels were mixed. Most people told us there were not always sufficient staff to meet people's needs safely. A person said, "Oh no, they don't have enough staff. Management failed to take account of staff absence and holidays." A visitor said, "In one sense they have enough staff and not in another when there are holidays, sickness or staff turnover. I know staff are doing extra shifts to cover. The home is doing its best to recruit. [My family member] had a fall. The fall was due to not enough staff."

Another visitor said, "Would there ever be enough [staff]? They could do with more staff. There are days when they need more staff." A third visitor told us they had observed a number of occasions where only one staff member was present in the lounge. This staff member had been responsible for providing constant one to one care and supervision for one person. The visitor told us there were usually a number of other people using the service also present in the lounge at that time who could not have been cared for by the staff member without the staff member leaving the person they were responsible for.

A member of staff said there had previously been problems with staffing levels but since the new management team had been in place it had improved. They said, "Since [names of managers] have been here they are trying to ensure we get cover when there is sickness. They try to get cover from our own staff and we can go to agency if needed." Some staff felt they had sufficient time to complete their work effectively. However, other groups of staff including care staff felt they did not always have sufficient time.

A staffing tool was used to inform decisions about staffing levels. Management explained that people's dependencies were considered when setting staffing levels. During the inspection we observed care staff generally promptly attended to people's needs and call bells were responded to within a reasonable time. However, staff on the first floor were busy and appeared stretched at times.

We also saw a lounge on the first floor was not always supervised where appropriate. During the afternoon of the first day of our visit we saw there were two people living with dementia in one of the upstairs lounges. There were no staff with them and we did not see any staff for over ten minutes. Shortly after a member of staff came out of a bathroom with a person using the service and assisted them to sit down just outside the lounge. The member of staff did not go into the lounge and one of the people in the lounge starting shouting intermittently "Somebody help." They went on to shout, "I'm bleeding, somebody help." We checked they were not bleeding but did not intervene. For a total of 15 minutes there were no staff in the lounge and the person's calls were unheard. We were informed following the inspection that one of the upstairs units had been closed to ensure staffing levels remained appropriate across the home.

Most people felt the home was safe. A person said, "I feel safe here and trust people to look after me." Another person said, "I like the place. I have had no falls and it's safe here." A visitor said, "I think the place is

safe." All people said they would speak to staff if they had any concerns.

Staff were able to identify signs of abuse and told us they would report any concerns to their immediate supervisor or to the manager. However, not all staff knew the details of any external organisations to which they could report concerns if necessary. A safeguarding policy was in place and information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety.

People told us they were kept safe but were not unnecessarily restricted. A person said, "I can leave and go to shops, pub and a little local park. I don't go alone. There is also a garden here that I go into." Another person said, "I can go around the space in here. The [staff] go with me in the garden." A visitor said, "[My family member] makes his choices as much as he can. He can go and have a lie down, go to bed or go to the garden when he wants."

We saw documentation relating to accidents and incidents and the action taken as a result, including the involvement of external professionals. There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans (PEEP) were in place for all people using the service. This meant staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place and available for staff to ensure people would continue to receive care in the event of incidents that could affect the running of the service.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. Appropriate checks had been carried out before staff members started work. We were told that proof of identity documentation for prospective staff was not currently being held at the home but at the head office. Plans were in place to ensure that all recruitment documentation was stored at the home.

People did not raise any concerns about medicines management by staff. A visitor said, "It's hard work to give [my family member] medicines. He is paranoid and thinks they are trying to poison him sometimes. Sometimes he takes them but not always. They will try three times by coming back but won't force him and he can miss a dose. So I discussed this with nurse and the doctor and agreed that they could put medicines in his porridge but not his drinks. I don't want him to lose his confidence in drinking." Another visitor told us their family member received pain relief when they needed it.

Staff received training and had their competency to administer medicines assessed. That helped to ensure people received their medicines in a safe way.

Requires Improvement

Is the service effective?

Our findings

During our previous inspection on 7 June 2016 we found people were not always effectively supported in making decisions about their care. The provider sent an action plan to tell us how they would become compliant with the regulation. At this inspection we found the regulation had still not been complied with and more work was required.

There were mixed views on whether staff explained what they were doing. A person said, "[Staff] don't explain what they are doing with you." A visitor said, "Staff do explain what they're doing such as when they persuade him to eat or explain to him how his medicines will help him." Another visitor said, "[Staff] always speak and tell [my family member] what they are doing." However, people told us staff respected people's wishes. A visitor said, "Staff stop if there are any issues and come back later." We saw staff did not always check with people before putting a clothing protector on them at mealtimes.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Mental capacity assessments were completed and best interest decisions were recorded for specific decisions for one person who was unable to make those decisions for themselves, however, mental capacity assessments had not been completed for another person who records stated they did not have capacity to make any decisions. We did not see consent or mental capacity assessments for the use of bed rails or use of a sensor mat. This meant people's rights were not fully protected in this area.

Staff did not know who had an authorised DoLS in place. The service had a DoLS planner in place which listed all authorised DoLS and the date of expiry of the authorisations. However, this planner had not been kept up to date and some authorisations had expired without any evidence seen that staff had re-applied. This meant people's rights were not fully protected in this area.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Views were mixed on whether staff were capable and competent in their role. A person said, "Many experienced staff have gone and there are too many new staff who are not fully trained." Another person said, "Staff are definitely well skilled." A visitor said, "Some staff are excellent but some of the youngsters are

finding their way." Another visitor said, "I think staff know their job." However, a third visitor said, "Staff competency is mixed. Some care staff don't understand the bigger picture and their clinical knowledge can be poor. This may be a training issue."

Not all staff had received appropriate induction before starting work at the home. Management told us they had identified this and were ensuring all new staff completed a corporate induction and a more detailed local induction. Training records showed a significant amount of staff had not attended or were out of date with mandatory training which included equality and diversity training. A review of this had been undertaken by management and plans, including training dates, were in place to ensure staff attended all mandatory training. We observed that not all staff worked safely and competently at all times. This meant staff were not fully supported to have the skills they needed in order to effectively meet people's needs.

Some staff could not recall receiving recent individual supervision. The service did not have a supervision matrix or planner in place in order to check and monitor all staff were receiving regular supervision. We checked the records for three staff and two staff did not have a record of receiving supervision. We were told supervisions were not taking place as frequently as set out in the provider's policies. This meant staff were not fully supported to maintain and improve their skills in order to effectively meet people's needs.

A visitor said, "Some staff know how to distract [my family member], some do not." This person could get distressed and anxious at times when receiving care. We observed staff responding appropriately to a person in distress. We were told some of the people using the service had behaviours which challenged and were resistive to personal care. A member of staff said sometimes three staff were required and staff would hold the person's hands to prevent them hitting staff during personal care. The member of staff said they had not received training in restraint or managing challenging behaviour. Care records also did not contain sufficient guidance for staff on how to effectively support people at times of high anxiety or distress. This meant staff were not fully trained or provided with clear instructions to effectively support people with behaviours which may be of a challenge to others.

A visitor was not happy with how their relative's healthcare needs were being met. They told us they were concerned about whether staff had the knowledge or skills to manage their family member's healthcare needs and had observed issues of concern. They had raised these concerns with management and told us that some things had improved, but others had not. They said, "I would get peace of mind if things were done properly; but I don't always have peace of mind."

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed care records for people who had a decision not to attempt cardio-pulmonary resuscitation order (DNACPR) in place. We saw DNACPR forms had not always been fully completed. The registered manager agreed to contact the relevant healthcare professional to ensure the forms were reviewed.

Feedback on the quality of the food was positive and people told us they had choices and their nutritional needs were met. A person said, "The food is brilliant. I get a choice and use foam grip handles. There is plenty to eat and drink. I can feed myself and get the [staff] to cut it up." A visitor said, "Staff are very accommodating. [My family member] gets sufficient to drink and staff know her preferences." People received food that met their cultural or dietary requirements, for example, a person who enjoyed Caribbean cuisine.

We observed the lunchtime meal in three different dining areas. In two of the three areas observed, staff

appropriately supported people to have sufficient to eat.

However, the mealtime experience in the other area required improvement. The tables were set with a tablecloth only and no place mats, condiments or menus. There was no background music playing and the mealtime was not a pleasant, sociable occasion. Most people were not offered drink choices and when one person, who was offered a choice, asked what the difference was between cranberry and orange juice, the staff member replied, "There is no difference. Same juice, different name." All staff either did not explain meals or described the potato and leek soup as "Vegetable soup."

Staff did not assist people promptly. This meant that one person was observed to be sitting at a dining table without any food in front of them while the other person sitting at the table was offered and ate from a range of different meals. At another table, due to lack of supervision, a person poured their drink onto the lap of another person using the service.

Staff also started talking to a person about dessert and then put their dessert out next to them while they were still eating their main meal. This meant there was a greater risk that the person would stop eating their main meal in order to eat their dessert which might compromise their nutritional intake.

People told us they had sufficient to drink. We saw people were offered drinks throughout the inspection. When people needed encouragement to drink sufficient fluids, fluid targets were set and records were kept of the amounts they drank. Records indicated that although they did not always reach their fluid target, they received adequate fluids to maintain their hydration.

Adaptations could be made to the design of the home to better support people living with dementia. People sitting in one of the areas did not have access to the current day, date and time and we also noticed it was not clear from the outside whether some toilets were engaged or not, which meant a greater risk that people using the toilet would be unnecessarily disturbed.

The layout of the premises was confusing and there was no directional signage to support people to find their way around the home independently. We observed a person, who walked continuously throughout the day, trying to enter other people's bedrooms.

Reception staff used an intercom throughout both days when requesting staff for telephone calls or other reasons. This intercom could be heard in all parts of the home and meant the atmosphere of the home was negatively affected. On one of the days of inspection it was raining hard and we saw water was pouring out of a gutter onto the courtyard outside people's bedrooms. This would have disturbed people living in those bedrooms.

Most people told us they were supported with their healthcare needs. A person said, "They are very good at getting doctors for my chest. I use the chiropodist regularly. Dentist visits twice each year and an optician visits." Another person said, "I have a doctor who comes regularly and the staff keep me in touch with him. I had new glasses. A dentist is being chased up." A visitor said, "[My family member] has been to hospital for a fall at night. I went with him and the home sent some notes. The G.P. visits every Wednesday and the nurse will put him on the list if he needs to be looked at. His chiropodist needs and haircuts are done. I tell the [staff] and they get it done."

Care records contained a record of the involvement of other professionals in the person's care, such as the speech and language therapist and the dietitian. This meant external professionals were involved to support people's healthcare needs as appropriate.

Requires Improvement

Is the service caring?

Our findings

People told us staff respected their privacy and maintained their dignity. A person said, "Yes I think these things are respected." Visitors told us staff generally respected their family member's privacy and dignity. A visitor said, "The door is knocked on before coming in and [my family member] gets privacy when getting cleaned or washed." Another visitor said, "[My family member] doesn't like to be changed so they explain to him that he is wet and he understands why he needs to be changed. The curtains are closed when they do and they talk to him about what they are doing." A third visitor said, "The respond quickly when [my family member] strips off in the lounge. However, she isn't always wearing a bra when I visit."

Staff did not always protect people's privacy and dignity. We heard a staff member saying to a person loudly, "Do you want a wee wee?" We also saw a staff member come out of a person's bedroom leaving the door open and carrying a continence pad. We checked the bedroom and a person was lying on the bed exposed which did not respect their privacy. Another staff member speaking to a person in a corridor said loudly, "We need to put some clean pants on you now!"

We saw old care records were not stored securely which meant that people's privacy was not respected at all times. Staff were also observed standing in the middle of lounges using their handheld devices to record care provided without interaction with people using the service. Staff did not always speak about people in a way that respected their dignity; they talked about people in front of other people, and we saw a staff member standing over a person when assisting them to eat which did not respect their dignity.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff were generally kind and caring, especially the permanent staff. A person said, "Established staff are kind. New staff don't know me. I've seen a lot of agency staff and that has only recently stopped." Another person said, "Not much wrong with [staff]. Oh yes they are kind." A visitor said, "There is a lot of kindness and banter. [Staff] give [my family member] a cuddle and a kiss." Another visitor said, "They are very kind and very patient. I have seen staff give people a hug." A third visitor said, "Staff are lovely. They love [my family member]. They give her a hug and are very caring."

People told us permanent staff knew them well, agency staff did not. A person said, "Established staff do but not the new ones." Another person said, "The staff know me." A visitor said, "The staff know [my family member] well. They did a life story work with [my family member] in his room. New staff may not know him so well." Some staff had a good knowledge of the people they cared for and their individual preferences, others did not.

We saw some warm interactions between staff and people using the service. Some staff effectively responded to people showing signs of distress, offering them reassurance and kind words. However, other staff appeared emotionally distanced from the people they cared for and although we did not observe any inappropriate or uncaring behaviour, they engaged purely with a task focus and did not make an effort to

involve them in any conversation or activities.

Staff ensured people were appropriately covered when they used equipment to assist them to move. Staff were observed to knock on people's doors and waited before entering. People were addressed by their preferred name as identified in their care plan. There were areas in the home where people and visitors could have privacy if they wanted it.

People had not seen a care plan recently, especially since the transfer to electronic care records. A person said, "I haven't seen a care plan for a year or more. Maybe two years. Don't know about any reviews." Another person said, "I'm not aware of any care plan." However, visitors felt more informed about their family member's care though still felt the move to electronic care records had affected this. A visitor said, "Yes I have seen it [care records]. I did a review of it and my views were taken." Another visitor said, "There is a care plan. I haven't seen it for a bit. I think it's on [an electronic device] now. If care changes they will talk with me every month and listen to my point of view. An example would be his medication and his paranoia. I chatted with staff and the doctor about these." A third visitor said, "I went through the care plans before [electronic records introduced]. They are more difficult to see on the new [electronic devices]."

There was no evidence of involvement of people or their relatives in the development of their care plans. A manager told us they were working with the company developing the electronic care record to identify the best way of incorporating evidence in the electronic record. This meant people could not be assured their views were taken into account during the care planning process to ensure that the care provided met their personalised needs.

A visitor told us their family member did not always understand some of the staff talking to her especially if they had strong accents. Their family member became distressed when this happened. We observed staff did not always clearly communicate with people or give people sufficient time to respond to any questions. We also saw that not all staff wore name badges which would make it difficult for people to identify staff members.

People and relatives were not aware of any advocacy information. A person said, "A nurse recently said that she was my advocate. I told her she was not. This struck a discord with me. There is no information on advocacy. Perhaps nurses here have been doing things for me without talking to me." Advocacy information was not available for people if they required support or advice from an independent person. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

A visitor said, "They allow [my family member] to do as much as they can." Staff also told us they encouraged people to do as much as possible for themselves to maintain their independence.

People told us there was no restriction on when they could receive visitors. A person said, "My friends can visit me anytime." A visitor said, "I can visit anytime. My daughter comes on Saturday and son comes on Sunday." Another visitor said, "I can visit whenever, morning, noon and night. They always make me a cup of tea, staff are very hospitable." Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the information guide for people who used the service.

Requires Improvement

Is the service responsive?

Our findings

People and visitors had mixed views on whether they felt they or their family member received support that was responsive and personalised to their needs, especially activities.
A person said, "I go out of the home with help. I go to the local shops, pubs and garden. The home has just started to do activities. A new activity co-ordinator has been recruited. We had an entertainer two weeks ago." Another person said, "I do a lot of things." A visitor said, "There are not many activities at present. A new activity co-ordinator is just starting to build it up. I play cards and dominoes with [my family member] and other residents when I visit." Another visitor said, "I haven't seen any activities recently."

We spoke with the activities coordinator who had only recently started their role. They had been recently working as a care staff member and not activities coordinator due to staff shortages. A limited activities programme was in place and it was clear the activities coordinator did not have enough time to provide sufficient activities for the people using the service. Activities records were very limited for most people and showed almost all people using the service had not been supported to leave the home for any activities or trips.

During the day no activities were observed in 1:1 or group situations. Observation in all four unit lounges during the day showed most people were inactive. Occasionally staff members were seen to use dolls with two residents on one unit and to engage people with conversation or to gently sit and stroke their hands.

An initial admission assessment was completed of people's care and support needs. An electronic care planning system was in place and the service were in a period of transition between electronic and paper records. As a result, some of the care records was stored electronically and this was supplemented by a folder with paper records. Locating information within the records was difficult. The records were difficult to navigate and information hard to access.

Care plans provided basic information about people's care and support needs; however, the information contained a number of standardised statements which were generic and not always helpful in understanding a person's specific needs and preferences. For example, "I know I am sometimes difficult to handle when I display challenging behaviour, but accept me as the person behind the behaviour. Strive to understand the meaning behind the behaviour." A person's continence care plan stated they were doubly incontinent but did not state how their continence issues were managed.

There was a lack of health care plans for people's specific health needs. For example, the eating and drinking care plan for a person who had diabetes, provided information on their dietary needs and the signs and symptoms of low and high blood sugar levels. However there was no diabetes care plan so, information such as the requirement for annual diabetes reviews, and other regular screening required was not included in the person's care records.

Another person's blood sugar levels were being monitored weekly. There was no time of the test documented, only the date, and no record of whether the test was performed before or after a meal. There

was no evidence of any trends in the readings or any evidence of when this should be reviewed or acted upon. The care plan indicated this person should be monitored for signs of low or high blood sugar levels, but did not provide details of the symptoms to watch for or the specific action to take in response.

A person had two pressure ulcers and we found wound assessment and progress charts were in place that provided details of the dressings used, the frequency of dressing changes and the size of the ulcer. However, these were completed sporadically and we found a gap of four weeks between records for both ulcers.

When people were at risk of developing pressure ulcers, care plans were developed, however, the information contained in the care plans did not always specify the frequency of the preventative actions and contained generalised statements rather than being specific to the needs of the individual. For example, a person's care plan stated staff should, "maintain turns" rather than stating how often the person should be assisted to change their position.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views on whether staff responded promptly when they rang their call bell. A person said, "Yes the staff come within minutes if I need them." Another person said, "[Staff] come within 10 minutes if I call." A visitor said, "[Staff] do [come quickly] but if staff are short then it's a struggle. But they do reassure people if they have to wait." We observed staff generally responded to people promptly and call bells were responded to within a reasonable time.

People told us that if they expressed a preference for a particular gender of staff member when receiving personal care then this was respected. A person said, "I prefer a woman carer and get one if I need it." A visitor said, "When [my family member] came in he didn't want a man helping him on the toilet and preferred a lady." This had been respected by staff.

The guide for people who used the service contained information on how people's beliefs and practices would be respected. However, no one we spoke with had particular beliefs or practices they wished to follow.

Everyone spoken with was aware of the complaints procedure but were not always happy with how complaints were responded to. A person told us they had raised a complaint but was not happy with how it was dealt with. A visitor said, "I have made complaints and had meetings. Some concerns were acted upon, some were not."

We saw complaints had been handled appropriately and responded to correctly. Guidance on how to make a complaint was displayed and it was also detailed in the information guide for people who used the service. However, it did not provide contact details for all relevant external organisations in the event of the complainant being unhappy with how their complaint had been handled by the service.

There was a clear procedure for staff to follow should a concern be raised. Staff were able to explain how they would respond to any complaints raised with them.

Inadequate

Is the service well-led?

Our findings

We saw audits had been completed by the registered manager, other staff and representatives of the provider. Audits and checks were seen of a number of areas including medicines management, infection control, health and safety and care records. However, it was not clear that actions had been completed in response to issues identified from the audits. Audits had not identified and addressed the issues we found at this inspection across the service, including the areas of managing risk, medicines, infection control, pressure care records, dignity and privacy, care plans, activities and MCA decisions.

Improvements to the service had not been made and sustained following inspections by us. The CQC inspection in September 2014 identified breaches in regulations. Our inspection in April 2015 found all regulations had been complied with, but the service was rated 'Requires Improvement'. At our previous inspection in June 2016 the service was rated 'Requires Improvement'' and we identified a breach of regulations and a number of areas were also identified as requiring improvement. These had not all been fully addressed by the time of this inspection. This meant effective processes were not in place to ensure that improvements were made and sustained when required.

People and visitors had not attended any meetings where they could discuss their views on the quality of the care they or their family member received. A visitor told us they had attended one meeting held following the death of a person using the service. Another visitor said, "We couldn't attend the last meeting as the notice was only put up the day before." We saw only one meeting had taken place recently and this was in response to the death of a person using the service. The guide for people who use the service stated meetings took place every three months for people who use the service. We saw no evidence any recent meetings had taken place for people who use the service.

Some people told us they had received questionnaires. We saw completed questionnaires and concerns had been raised by people regarding activities, "There are none." Only four of 20 people were happy with, "Trips away from the home". The survey results were dated February 2017 and we saw the concerns regarding activity provision had not been addressed by the provider by the time of our visit.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A number of representatives of the provider had visited the home or were working in the home following the departure of the registered manager. As a result of this, a number of shortcomings had been identified and an action plan had been produced to address these shortcomings. The action plan covered the areas of management, staff, environment, activities, catering, health and safety and administration. This action plan covered the majority of the issues identified during our inspection and clear actions, responsible people and timescales were in place. Management told us it was clear that audits had not identified and dealt with issues previously so a new audit schedule had been put in place to ensure all areas were being audited in future.

A whistleblowing policy was in place and information was also displayed in the home. However, not all staff were aware of this policy.

The provider set out a residents' charter and a philosophy of care in their statement of purpose which was available for people using the service. A statement of purpose (SOP) is a legally required document that includes a standard set of information about a provider's service, including the provider's aims, objectives and values in providing the service. We saw staff did not always act in line with these values during our inspection.

Views were mixed on the atmosphere of the home. A person said, "The atmosphere here is difficult and not getting better. It's pretty bad." However, another person said, "It's nice." A visitor said, "I'd give it eight out of ten. At present the home has some problems. The previous manager left only a few weeks ago." Another person said, "The previous manager was always okay with me. The atmosphere changed after she left. A man died of choking. There was a lot of tittle tattle at that time. But everyone was okay with us." A third visitor said, "I didn't like the atmosphere initially, the home was quite a scruffy place."

People had mixed views and understanding of the management of the home. A person said, "I have never spoken to the two acting managers. No one has introduced themselves. The compliance manager is friendly and talkative. The managers have not been approachable. The place is Dickensian. It needs people and a manager who treat staff and residents with the respect they deserve." Another person said, "I don't know the manager and have never talked to him." A visitor said, "The previous manager has gone. The acting up managers are from national senior managers group. A new manager is being recruited. I have seen the acting managers walking about the home." Another visitor said, "I am comfortable with the managers. She has introduced herself and occasionally had a greeting from her. I think she is approachable. But if I had a question I would ask a nurse."

Staff were familiar with the interim manager supporting the service as they had visited the service regularly in the past. They said he was, "really approachable" and they felt able to report concerns or issues to him. Staff were similarly positive about other representatives of the provider who were working in the home following the departure of the registered manager.

We saw staff meetings had not taken place recently and it was not clear from previous staff meeting minutes seen whether actions had taken place in relation to identified concerns. Those minutes seen indicated very few staff had attended a recent staff meeting.

A registered manager was registered with the Care Quality Commission (CQC); however, they had recently stopped working at the service. A representative of the provider was present both days of the inspection and told us they would be applying to register as manager for the service. We saw all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required. The current CQC rating was displayed in the home and on the provider's website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive support that met their individualised needs. Care records did not provide staff with sufficient information to meet people's individualised needs. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not always protected under the Mental Capacity Act 2005. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment.

	Regulation 12 (1) (2) (a) (b) (c) (d) (g) (h)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff received appropriate induction, training and supervision. Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to regularly assess and monitor the quality of service that people received. Regulation 17 (1)

The enforcement action we took:

We issued a requirement for the provider to send us monthly reports on the progress they had made towards improving the service.