Regal Healthcare Homes (Coventry) Limited

Haven Nursing Home

Inspection report

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Tel: 02476368100

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1 March 2016 and was unannounced. Haven Nursing Home is a large nursing home which provides nursing care for up to 70 people, across three units. People whose primary care need is dementia, are mainly supported in Birch Unit. Older people and
people with more complex nursing needs are mainly supported in Oak and Elm units. At the time of our visit there were 38 people living in the home.

At our last inspection on 8 and 10 September 2015, we found there were six breaches in the legal requirements and Regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

These breaches were in relation to the support people received. Care was task focused, not focused on the needs of each person which meant individual needs had either not been identified or acted on. People's social care needs were not met because staff did not have the time to provide interests or activities for all. People in the Birch unit (a specialist unit for people living with dementia) experienced very little engagement to meet their social care needs; staff did not act in accordance with the requirements of the Mental Capacity Act 2005 to ensure that decisions to restrain people were in their best interest; the provider did not ensure the proper and safe use of medicines, or ensure there was always sufficient stock, to meet people's needs. The provider did not ensure risks were recorded and responded to appropriately; there was not an effective and accessible system for identifying, receiving, recording, handling and responding to complaints; the provider did not have effective systems and process to make sure they assessed and monitored their service to ensure compliance with the requirements of the Health and Social Care Act 2008. People were not receiving the personal care they required to be safe, because there were insufficient staff to meet their needs; staff had had not received training to enable them to support people living with dementia.

We issued the provider with a Warning Notice in relation to the lack of effective oversight.

As a result of the September 2015 comprehensive inspection, the provider was put into special measures. We asked the provider to take action to improve the areas we had identified as being of concern. The provider sent us an action plan which detailed the actions they were taking to improve the service. This inspection found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

Following our September 2015 inspection, a new manager was appointed but had since left so that at this inspection visit, the home did not have 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.

Since the September inspection, whilst there had been some improvement in the management of

medicines, the provider had not done enough to ensure people received their medicines safely and as prescribed.

The provider had taken action to ensure enough staff were on duty to meet people's needs. They were no longer in breach of the Regulations of the Health and Social Care Act 2008. However, staff said they felt under pressure at times and struggled to meet people's needs. The provider also continued to use agency staff to provide care to people, but recruitment for more permanent staff was underway.

Staff were clearer about their responsibilities under the MCA and DoLS legislation and were no longer in breach of the Regulations of the Health and Social Care Act 2008. Plans were in place for people who lacked capacity to ensure they were not restrained unlawfully, for example by the use of bed rails. However, the provider acknowledged applications might need to be made to deprive people of their liberty, and plans were in place to do this.

The provider had taken some action to ensure people living with dementia were properly supported, and was no longer in breach of the Regulations of the Health and Social Care Act 2008. Staff had received some training, and people living with dementia had been reassessed to ensure their needs could be met.

Staff were respectful and treated people with dignity and respect. We observed this in interactions between people, and records confirmed how people's privacy and dignity was maintained.

People continued to be supported in ways that were task focussed and were not person centred. Care plans did not support staff to provide personalised care consistently as they had not been reviewed and information in them was not always accurate.

The provider had not taken steps to ensure effective systems were in place to check the quality and safety of service provided, and there was a lack of governance which made it difficult for the service to improve.

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

Requires Improvement

The service was not consistently safe.

Medicines were not being managed safely and there were no systems in place to monitor and check this. It was not possible to ensure people received their medicines safely and as prescribed.
Risks were not always properly assessed and managed.
There were enough staff on duty to meet people's needs and staff knew what action to take to safeguard people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's capacity to understand and make decisions had not always been assessed as required. The provider had recognised the process to ensure people who lacked capacity to make decisions were safe needed to be reviewed and there was a plan in place to do this.
Training was planned in order to ensure staff had fundamental knowledge required to support people safely, but new starters had not been provided with the support they required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives told us staff treated them with dignity and respect. We observed this to be the case during our inspection visit.
Most people had their privacy maintained and staff asked people's permission before supporting them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were given some opportunities to follow their interests or be involved in social activities, but this was not consistent throughout the home. Care was not responsive to people's individual likes and dislikes or their specific needs as plans were

not always in place where people had specific health conditions for example. Complaints were not responded to in a timely or satisfactory way, but there was a new policy in place to make it clear for people and their relatives what they could expect.

Is the service well-led?

Inadequate

The service was not well-led.

A new manager was appointed following our inspection in September 2015 who has since left. A team of consultants have now been employed to manage the service and we saw plans were in place to demonstrate how things needed to improve. However, there was insufficient evidence that effective systems were yet in place to check the quality of the service being provided and to improve it as a result. The provider did not have oversight of the service.

Haven Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 01 March 2016 and was unannounced. The inspection was conducted by two inspectors, one inspection manager, an expert by experience, (is someone who has experience of caring for a relative), a Nursing Specialist Advisor, and a Pharmacist Inspector.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law. We also considered information we received whilst the service had been placed in special measures following the September 2015 inspection.

During our inspection, we spoke with 10 people who lived in the home. We also spent time observing interactions between people and staff. We spoke with seven relatives, and one health professional. We also spoke with two consultant managers and 11 staff.

We reviewed eight people's care plans, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated to check how the provider gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 8 and 10 September 2015 we found the provider did not ensure the proper and safe use of medicines, or ensure there were always sufficient stocks to meet people's needs. This was a breach of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

During our inspection on 1 March 2016, we found that whilst there had been some improvement, for example in the ordering of people's medicines, the provider had not done enough to ensure people received their medicines safely and as prescribed.

Guidance for the administration of 'as required' medicines was not always available. This guidance provides information in the form of a protocol as to when it is appropriate to administer an 'as required' (PRN) medicine and ensures people receive their medicines in a consistent manner. However, we checked 18 people's MAR charts and found 10 people had no written protocols for PRN medicines. Eight protocols that were in place were found to be no longer prescribed for the person and in two cases, had not been reviewed. There was no documented reason on the MAR why people had received the medicines or the time it was given. We were concerned that there was insufficient information for staff to ensure that people were given them consistently and safely. Four people were prescribed medicines which were to be given to reduce anxiety or when people displayed behaviours that challenged. There was limited information to inform staff of measures they could take which could be used before people were calmed by prescribed medicines. This meant there was a continued risk medicines may be administered before all other interventions had been explored.

Four people received their medicines in a covert manner. Covert administration of medicines may take place when a person regularly refuses their medicine, but they lack the capacity to understand why they need to take the medicine. This can include the crushing of medicines and adding them to liquid. The nursing staff member who administered the persons' medicines told us no information had been obtained from a pharmacist regarding the safe crushing of medicines. One of the medicines that was crushed, was a tablet designed to release slowly and this would have changed how it affected the person.

Nursing staff had not received training in the administration of medicines in the past 12 months, nor had they had any competency checks carried out with regard to administration of medicines. This meant the provider could not be assured staff continued to administer medicines safely.

Medicines were stored safely and securely, in locked trolleys in the locked treatment room. Medicines that require additional controls because of their potential for abuse (controlled drugs) were stored securely. However, medicines requiring cold storage to work effectively, were kept within an unlocked monitored refrigerator in the treatment room. Monitoring of the refrigerator temperature to ensure that these medicines were stored at a safe temperature, had not always been completed and staff had not taken appropriate action after temperatures were documented outside the safe range. There were medicines stored in the refrigerator at the time of the inspection, but there were no procedural documents in the home relating to refrigerator monitoring.

Nursing staff took care to ensure the correct medicine was administered to the right person. One person who was prescribed medicines that required regular monitoring, had regular tests and one person on time dependent medicine was given them at the correct time intervals. However, we noted four people prescribed topical medication had incomplete body-map application records. This meant there was a risk people would be given more of this medicine than they were prescribed.

There were no documented audits of the clinic room including temperature monitoring, MAR charts administration, completion of CD daily audits, waste management and return of medicines, and stock levels of medicines. There was no evidence of error reporting directly by staff, discussion or shared learning from errors. However, staff were able to say how they would report an error if it occurred.

This was a continued breach of Regulation 12 (1) (2) (g) HSCA (RA) Regulations 2014 Safe Care and treatment.

There were clear and effective systems and processes of ordering and receiving medicines.

Administration of medicines was recorded clearly on MAR (Medication Administration Record) sheets, which were provided by the pharmacy. There were no omissions in the administration records. Medicines in stock matched the administration records recorded by the home and stock balances were accurate. The provider maintained accurate and up to date records for the receipt and disposal of medicines. MAR charts had handwritten additions or changes to them which had been checked and signed by a second member of staff.

Risks relating to people's care needs had not always been identified and assessed. Where they had, these assessments were not always up to date as many had not been recently reviewed. Some risk assessments had contradictory information in them, which made it more difficult for staff to know how best to manage people's risks. For example, some people were at risk of skin tissue breakdown. Care records showed that where people were at risk of this, they had been assessed but their risk assessments had not been reviewed and it was difficult for staff to get up to date and accurate information about how risk should be managed. Records also showed that people's risk had been 'scored' using risk assessment tools to help identify those who were at higher risk. This had not been done consistently and was sometimes based on out of date information. Staff we spoke with were able to tell us how to manage people's risks, but given that the provider used agency staff to ensure there were sufficient staff on duty, there was potential for these risks to not be managed safely.

Other risks, such as those linked to the premises, or activities that took place at the service, were also risk assessed and agreed actions to minimise those risks. This helped to ensure people were safe in their environment. Routine safety checks were completed for the premises, these included gas checks and checks on electrical items. However, some of these checks were out of date and it was difficult to tell from the records when they were next due to be completed. During our inspection, we did not identify any concerns relating to maintenance of the home. Staff knew what arrangements were in place in the event of a fire and were able to tell us about the emergency procedures they would follow. Care records showed people had personal fire evacuation plans in place which took account of their needs and guided staff on how best to support people in the event of a fire.

Risks to people's nutrition and hydration were not always minimised effectively. The consultant manager told us they had identified food and fluid intake was not always being monitored where people had been identified as being at risk, and that where it was monitored, records were not always being completed. They told us they had introduced new recording mechanisms, and had provided some training to staff on how to

complete them. Care records showed that people had nutrition care plans for staff to follow. However, information was sometimes conflicting which made it difficult for staff to know how to support people safely. For example, one nutrition care plan indicated a person's weight should be monitored regularly. However, their weight had not been recorded since 19 December 2015. We looked at weight monitoring records for seven other people where it had been identified they were at potential risk. We found these records had not been regularly updated, which meant there was a risk that people might be losing weight and that this might not have been identified and the necessary support provided. Feedback from the dietician working with the home indicated there were some concerns about how people were being supported with their nutrition. They advised that staff had consistently failed to complete risk scoring tools on a monthly basis, had not demonstrated that they were putting in place dietary interventions to improve nutritional status, care plans were not up to date, inconsistent weight recordings were not questioned, and dietetic care plans were not being followed.

This was a continued breach of Regulation 12 (1) (2) (a) (b) HSCA (RA) Regulations 2014 Safe Care and treatment.

Staff knew how to ensure effective infection control measures were in place. Staff we spoke with were able to tell us about precautions they would take in order to reduce the risk of infection, and were able to tell us how they would deal with infection if it was present. We also observed staff taking appropriate infection control measures such as putting on clean disposable aprons and gloves before helping people to eat, for example. However, on the day of our inspection visit, a number of items of furniture were ripped, torn and had holes in them. We discussed this with the consultant manager who agreed this posed a risk of cross infection not being properly controlled. They told us they would ensure this furniture was replaced as soon as possible.

At our last inspection on 8 and 10 September 2015 we found the provider did not ensure there were enough staff on duty to meet people's needs. This was a breach of Regulation 18 (staffing) of the HSCA (RA) Regulations 2014.

During our inspection on 01 March 2016, we found there had been some improvement and that there were enough staff on duty to meet people's needs. The provider had begun to use a 'dependency tool' to establish how many staff were needed to support people properly. The consultant manager told us people's level of support needs had been assessed and staffing had been determined based on the needs of people across the home. Relatives we spoke with had mixed views on whether or not there were enough staff. One relative, who told us they visited their family member most days, said the home was, "100% better than it was before when there were hardly any staff." Another told us they felt their relative sometimes had to wait too long for help with their personal care and that this was due to a lack of staff. We spent some time observing how people received their care in communal areas of the home at different times of the day. We saw people's needs were met, and they received support when they needed it. For example, one person fell in one of the lounge areas. A number of staff were on hand quickly to support the person and check for any injuries. We also saw a number of people assisted by two members of staff to help them move safely from a wheelchair to a chair. When people rang call bells in their rooms for support, staff attended to them in time to be able to support them.

We found there were enough staff to support people over the lunch time period. People did not have to wait for their food, or to be assisted and staff stayed with people until they had finished. However, staff told us it could be 'stressful' working at the home, and that, at some points during their working day, they found it difficult to maintain the level of support people needed and as a result felt under pressure.

The provider used agency staff in order to ensure sufficient staff were on duty to meet people's needs. Staff had to give clear direction to agency workers who did not always understand what was expected of them, or of people's needs, where they were at potential risk and how they should be met. We saw in one lounge a member of staff had to intervene when two agency workers were using a hoist, as the staff member was concerned they were not doing this safely. One of them did not appear to know whether a brake was on or off a wheelchair. The same person appeared not to know how to support a person to move from their wheelchair to a dining chair. Another agency member of staff intervened and provided re-assurance to the person they were going to be okay. We spoke with the consultant managers about this, who confirmed they had ensured one of the agency workers who was working on the day of our inspection would not return. They also told us they were recruiting new staff to ensure there was a consistent staff team in place as soon as possible which would limit the need for agency staff.

Staffing records showed that numbers of staff on duty reduced from 7pm until the following morning. We spoke with the consultant manager about this and asked how they ensured the level of care needs across the home could be met with fewer staff at these times. They agreed they needed to keep this under review to ensure people received the care and support they needed when they needed it.

The provider's recruitment process ensured risks to people's safety were minimised. A recently recruited member of staff told us they had a DBS check which the home checked, but they had to wait for their references to be returned before they were offered employment. The Disclosure and Barring Service (DBS) is a national agency that keeps records of criminal convictions.

People told us they felt safe. One person said, "I can't go out of the building without someone helping me and that's okay, it feels safe like that." We spent time observing the interactions between the people living in the home and the staff supporting them. We saw people were relaxed and comfortable around staff and responded positively when staff approached them.

Some staff had recently received training in how to protect people from abuse and understood their responsibilities to report any concerns. They understood how to look for signs that might be cause for concern. One staff member told us, "If I saw something I would stop them and speak to whoever is in charge." There was more training planned for those who had not already attended.

There were policies and procedures for staff to follow should they be concerned that abuse had happened. The previous manager had made safeguarding referrals to the Local Authority. However, they had not always taken the action expected of them in response to these incidents in a timely manner. It was not possible to check written records of how safeguarding incidents had been managed as these were not available to us at the time of our inspection. We spoke with the consultant managers about this, who had already begun to respond quickly and effectively to safeguarding concerns. They agreed they needed to ensure detailed written records of safeguarding incidents were kept to help them ensure action was taken swiftly.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 8 and 10 September 2015, we found the provider did not always ensure people's consent was sought before any care and support was provided. We also found the provider did not always take decisions in people's 'best interests'. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 208. We were concerned staff were using bedrails as a form of restraint to keep people in their beds because their behaviour was challenging to them and others.

During our inspection on 1 March 2016, we found that staff had received training in how to support people whose behaviour might be challenging. Care records also showed that where bed rails were used and where people did not have capacity to make the decision for themselves, risk assessments were in place. Where the use of the bed rails had been made in people's 'best interests' this had been discussed with family members. Care records showed there had been discussion of how people might be supported to be kept safe without the use of bed rails, showing that other, less restrictive options had been considered. We found the provider was no longer in breach of this regulation.

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).

Staff told us about 'best interests' decisions and that they were following the principles of the MCA. For example, one staff member referred to a situation on the day of our visit. A person needed to be supported with their personal care and they did not want to be. After various attempts to do this with the person's consent, they made a best interest decision to change them, because of the potential risk to their health and wellbeing.

People's care records showed their capacity to make particular decisions had been assessed in line with the MCA. However, some of these were not up to date and this made it difficult to establish what support people might need with decision making. We spoke with the consultant manager about this, and about applications to the Local Authority where people were being supported in ways which might deprive them of their liberty. Care records showed a number of people did have DoLS applications which had been authorised, but their care plan did not always make it clear how people should be supported to ensure the authorisation remained lawful. The consultant manager told us there was a plan in place to review all existing DoLS applications and authorisations, and to ensure any new applications were made. They anticipated this work would be completed by 30 April 2016, but in the meantime, the consultant manager was working with staff to ensure they understood their responsibilities under DoLS.

At our last inspection on 8 and 10 September 2015 we found the provider did not ensure staff had the skills,

knowledge and resources to properly support people with dementia. We found this was a breach of Regulation 18 (Staffing) (2a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on 1 March 2016, we found some action had been taken to properly assess the needs of people in the home who were living with dementia. For example, some people were being supported in other parts of the home following re-assessment of their needs. We spent some time observing the support people on Birch, the unit for people living with dementia, received and saw that staff communicated well with people, were sensitive to their needs, and tried to provide good care. Whilst the provider was no longer in breach of Regulation 18 (Staffing) (2a), we spoke with the consultant manager who agreed more needed to be done to properly support people living with dementia.

The consultant manager told us they were working with the provider to review Birch unit to look at best practice around dementia care with a view to improving it. The consultant manager told us, "The dementia unit does not currently function like a specialist dementia unit. We need to decide what we want."

Staff told us they had not been well supported by the previous manager and had worked in the dementia unit with limited knowledge of people with dementia, which had made it difficult for them to provide proper support. Staff told us, "We don't have the proper instruction which staff had the right skills and knowledge to work in which area of the home." Staff told us that some staff did not like working in Birch because they did not feel equipped to support them.

Staff told us they had received training in safeguarding, MCA, and how to manage behaviour that challenges. The consultant manager told us that since they had started working for the provider, they had found training records were not updated, so it was not clear what training staff had completed and what was still required. They told us they had already arranged training on health and safety, risk assessment, person centred care, care planning and record keeping, some of which had taken place. They told us they would be looking at other training needs as people's care plans were reviewed and gaps in staff knowledge became clearer.

Staff told us they had received basic training but that they had not necessarily found this helpful as they had not been supported to put the training into practice. One staff member told us, "I have done my all basic training but looking at the current situation at this home with no management support, things will go wrong."

Staff who had recently started working at the home told us they had not received an induction, and it had been confusing when they started as they had not had any management support. One staff member told us, "The first four days were horrendous because no-one told me what I should be doing." Another staff member told us they had been working at the home for approximately three weeks and had not been provided with an induction programme. They said, "There is no manager, so I don't know who to talk to." We spoke with the consultant manager who told us they had ordered Care Certificate workbooks and were looking at drawing up detailed induction programmes for new starters. This would help staff in preparing them with a structured programme so they could support people properly. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

Staff told us they had the opportunity to talk to a manager when they needed to about issues relating to people and their care and support, but that they were not always sure who they should talk to and in what circumstances. Some staff told us they thought this had improved since the consultant managers had been appointed.

Whilst some people's food and fluid intake was not being properly monitored and recorded, we saw that people being supported on Birch unit had their food and fluid intake observed and recorded, even where this had not been identified as a risk. Kitchen staff were able to show us a list of people who had specific dietary requirements and how these were met. We also spoke with staff over the lunch time period, who told us how they monitored what people ate and drank and how they were now expected to record this.

We spent some time observing people eating over the lunch time period. There was a menu on display in the dining area. This indicated a choice of foods available, and we saw people were able to choose alternatives.

Where staff supported people to eat this was done in an unhurried manner, one member of staff described the food to people, frequently checked that the food was not too hot at the beginning of the meal and then checked that it had not cooled too much. They periodically offered the person a drink. They offered a choice of dessert and when the meal was finished they gently wiped the person's mouth having sought consent to do this.

We did not see any health care professionals on the day of our inspection; however care records showed that people had seen their GP when requested. For example, care records showed the GP had been involved in recent medication reviews. Other healthcare professionals such as the optician, dietician and chiropodist had also been consulted as necessary. However, one relative we spoke with told us they felt the GP was not always quick to respond, and that they had raised this with the manager of the home in relation to a recent illness their relative had been experiencing.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us staff were kind and caring and treated them with respect and we saw some examples of where staff interaction and attention to people's needs offered them reassurance and comfort. One person told us, "I am happy here, no one at home to look after me, so I do appreciate it." One relative told us, "Staff are kind and pleasant." We saw where people interacted on a one to one basis with staff, they seemed relaxed and responded well to staff involvement. However, up to and following our inspection in September 2015, the provider had not created an environment in which people were at the centre of the service, and people had not always experienced caring support as a result. The provider had not ensured they offered a caring service to people and whilst we saw improvement had been made, there was more to be done to ensure the care provided was centred on people as individuals (person centred care).

Staff were attentive to people's needs and were quick to react when someone appeared to be in discomfort. Staff reassured people who were anxious and distressed and responded promptly, calmly and sensitively. This was particularly evident with someone who had repeated periods of anxiety throughout the day. Staff communicated with people effectively and used different ways of enhancing their communication, for example by touch, ensuring they were at eye level with people who were seated, and altered the tone of their voice appropriately. We saw staff held people's hands and provided them with comfort. One agency member of staff was walking alongside a female resident saying, "Are you a Birmingham or Coventry girl?" The person seemed to respond positively to this conversation.

We saw people were asked for their consent and were supported in ways that were respectful. We spoke with people in regards to their personal care, they agreed they had been asked and one person said, "Staff respect me."

People's care plans contained limited information about people likes, dislikes, preferences and history. The plans were task focussed and not focussed on the individual. Staff we spoke with told us the care plans needed to be improved to make them more person centred. The consultant manager agreed and had identified that care plans were out of date, often contained contradictory information, and were task focussed. They told us care planning was a high priority for them, and that their initial focus was on ensuring care plans helped keep people safe, but that they would then move on to look at how care plans could be more person centred.

People were supported to maintain relationships with family and friends. Relative told us they visited people on a regular basis, and that they were made to feel welcome. One relative told us, "I can visit whenever I like – there are no restrictions. I also take [person] to my house and can drop her back at any time."

People's privacy and dignity was usually respected. Staff working in Birch (dementia unit) were seen to support people in a kind and compassionate way and supported people's dignity. They took people to their rooms to get changed, or to the bathroom to help them get cleaned. Staff were observed and heard to be discreet when people needed assistance. Staff were also observed and heard to knock on bedroom doors and identified themselves on entering the room. In the main lounge however, we saw agency staff hoist one

person in a skirt, no blanket was used to preserve the person's dignity.

Confidential and sensitive information about people was kept securely and was only accessed by those who needed to access it. This helped to ensure people's privacy and dignity was maintained.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 8 and 10 September 2015 we found people were not supported in a person centred way, and their care was task focussed and not focussed on the needs of individuals. This was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on 1 March 2016 we found that the provider had not done enough to ensure people received person centred care and support. We found there was a risk of a negative impact on people as a result.

People's care plans had not always been reviewed and kept up to date. This made it difficult for staff to respond to people's specific needs consistently and safely. For example, care records indicated that one person was at risk of deterioration in their health due a specific condition. There was no care plan to guide staff on how to manage this condition, or on what to look out for which might be a cause for concern. Another person had a PEG feed (a PEG feed is where food and fluids are inserted directly into a person's stomach). There were some records in place in relation to this, and measures were being taken by staff to support the person safely. For example, there was evidence the dietitian under took regular reviews of the person, and that the pre and post flush feed was clear. However, there was no care plan in place for the PEG feed. This person spent their day in the central lounge, there was no alert to warn staff that the person was nil by mouth, which was of concern as there were a lot of agency staff used who were not always familiar with people's needs. There was a risk the person could be given a drink accidentally or drinks for other people could be left within the person's reach. We raised these issues with the senior nurse on duty, who agreed care plans needed to be in place in response to people's specific needs, and action was taken shortly after our visit to rectify this.

People who had wounds or ulcers had records kept in relation to their condition. The quality of the records varied considerably. Some of the photographs were blurred making it difficult to describe accurately the extent of the wound and the health of the surrounding tissue. Care plans did not indicate how regularly further photographs should be taken. Not all wounds were measured to help inform the effectiveness of prescribed treatments and interventions. This made it difficult for staff to respond effectively to people's specific needs. However, a recent investigation had been conducted by the Local Authority following concerns about how a person at risk of skin breakdown was being supported. This investigation found staff knew how best to support the person, and that care in place to reduce the risk of skin breakdown was delivered in line with current best practice guidance.

People we spoke with told us, that they were not aware of their care plan or any other paper work. They told us they thought their relatives must have been involved. Relatives we spoke with said they were aware of people's care plans and had been invited to review them. Care records themselves did not evidence that reviews had taken place.
People told us there were not many activities taking place that they wanted to join in with. One person told us, "Once I went to conservatory to attend a coffee morning and there were only four people there." There

was an activity board on display indicating the activities for each specific day, but this was on display in an area of the home where people did not ordinarily go. People we spoke with were not always aware what activities were on offer on what days.
We saw no activities taking place in Birch unit and people we spoke with confirmed this. One relative told us Birch unit was "very isolated" and that people being supported there were not offered any "meaningful activities." Staff we spoke with told us they found it difficult to engage people in activity as many "are not interested." They also told us they did not often have time to do so. We spoke with the activities co-ordinator who told us they planned activities but there was often a lack of interest. They acknowledged little was done to engage or stimulate people being supported on the Birch unit.

This was a continued breach of Regulation 9(1) (a) (b) (c) HSCA (RA) Regulations 2014 Person Centred Care.
Two staff employed to undertake activities went to both Valerie and Oak lounges after lunch to undertake an organised music and movement activity. People clapped and sang to 'The Beatles' music and were encouraged by staff to throw a large ball around. We saw some people were engaged with this and from their expressions, were enjoying the activity. Staff also encouraged people to use some musical instruments and we saw one person who had been asleep, woke up and joined in, shaking their instrument. They were smiling and singing and looked happy to join in.

At our last inspection on 8 and 10 September 2015, we found the provider did not do enough to respond to complaints and concerns raised by people, and did not learn from them in order to improve the service provided. This was a breach of Regulation 16 (Receiving and acting on complaints) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on 1 March 2016 we found that the provider had taken some steps to improve the way complaints were handled, but that there were not yet systems in place to learn from complaints and improve the service people received.

Relatives we spoke with told us they had not been provided with any guidance from the provider on how to make complaints, but that they would approach the manager if they had any concerns. Relatives told us that due to frequent changes in management of the home this had been difficult. Relatives told us they had raised concerns and complaints with the previous manager and these had not been dealt with. One relative told us they had complained about the lack of activity happening on the Birch unit for example. They told us "nothing had been done" in relation to this. Other relatives told us they had not had any response to complaints raised and that they had not seen any difference in the service. For example, one relative told us that, following a person having a fall, they had been promised a ramp would be installed. They told us this had not happened and they had not received any explanation why not.

It was not possible during our inspection to look at a record of previous complaints made, as there was no recorded evidence of how complaints were received, responded to and resolved, and no indication of how information from complaints had been used to improve the service provided. There was a new updated complaints policy on display in the entrance hall so people could read what they could expect if they made a complaint.

In the short period of time that the consultant managers have been employed by the provider to work at the home, they had planned and conducted a meeting with people, staff and relatives to let them know about changes needed and to get their views. Relatives acknowledged this. The consultant managers told us they knew responding effectively to complaints was an area that needed some improvement. They were improving their complaints systems so they could manage and learn from complaints and improve the service people received.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 8 and 10 September 2015 we found the provider did not have proper systems in place to monitor, audit and improve the service being provided. There had been frequent changes in management which destabilised the service and provided inconsistent decision making. This was a breach of Regulation 17 Good Governance of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also issued the provider with a Warning Notice in relation to governance, requiring them to take action to improve this.

During our inspection on 1 March 2016, we found systems to monitor improvements were inconsistent and ineffective, although plans were now in place to address this. There had been further management changes and the service does not currently have a Registered Manager in post. We found the provider continued to have little oversight of the service, and did not have effective measures in place to check how the home was being managed.

The previous manager had been appointed following our inspection on 8 and 10 September. They had been supported by a consultant up until December 2015 when the consultant left the service. The manager had left the service approximately three weeks before our visit on 1 March 2016. Approximately two and a half weeks prior to this inspection, the provider had re-engaged the services of consultant managers to manage the service until a new manager was appointed. The provider had used these consultants before to make improvements but had not ensured this was sustained.

Current management arrangements consisted of three consultant managers, one of whom was present at the home three days per week, and the other two were at the home, each for one day per week. Cover was provided by the consultant managers at weekends. In the entrance foyer, information was on display indicating what days management cover was available. One of the consultant managers told us they had spoken to the provider about helping to recruit, induct and mentor a new manager to try to encourage a stable and effective management team at the home. The provider had already agreed to employ two existing staff as deputy managers for half the week each, and hoped this arrangement would begin in April 2016.

Relatives told us they were confused about management arrangements as they had changed so often. They also told us they did not feel the owner of the service took action when required. One relative told us, "In previous meetings the owner and manager agreed to improve many things but I am very disappointed as no improvement has been made."

Some staff told us they had already noticed some improvements since the consultant managers were appointed. Staff said they felt positive about the service going forwards. One staff member told us, "Within 2 weeks, things have improved. They have shown us the positive side. How we can improve ourselves and give better care." Another told us, "Working with [names of consultant managers] I'm really positive. I know they can turn it around." Other staff told us they had liked the previous manager and felt they were taking action to improve the service.

The consultant managers told us about the plans to check the quality of the service being provided with a view to improving it. They planned to check care plans, medicines and safety matters on a regular basis to give the provider assurance that things were improving. However, we found out of date medication records and protocols and care plans not matching risk assessments, which had not been identified as there had been no auditing systems in place. One of the consultant managers told us, "All the risk assessments and care plans were done in December 2015. It is all gone." "We are going back to basics. We are re-writing care plans and risk assessments. Our priority is ensuring people are supported safely."

We found that, whilst the ways in which the provider responded to complaints had improved, there were no systems in place for lessons to be learnt from complaints, and for the service people received to be improved as a result.

This was a continued breach of Regulation 17(1)(2) (a)(b)(c)(e) HSCA (RA) Regulations 2014 Good Governance, and the Warning Notice had not been met.

Staff confirmed they had staff meetings and that a number had taken place since the consultant managers began to manage the service. One staff member told us, "We have staff meetings, we make our point. We had a staff meeting on Saturday and discussed paperwork. Everyone should know what they are doing."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment was not focused on, and did not meet the needs of, each person. Service user's individual needs had not been assessed to ensure they were appropriate, or that their preferences had been taken into account. Regulation 9 (1) (a) (b) (c) HSCA (RA) Regulations 2014 Person-centred Care.

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 The provider did not ensure care and treatment was provided in a safe way. The provider did not ensure the proper and safe management of medicines, or ensure staff administering medicines were competent to do so. The provider did not ensure risks to service user's health and safety were properly assessed and reviewed, which meant staff could not always take steps to reduce those risks. Regulation 12 (1) (2) (a) (b) (g) HSCA (RA) Regulations 2014 Safe care and treatment

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 systems or processes to assess, monitor and improve the quality and safety of the service.

Service user's records did not accurately reflect the care and treatment provided, or how risks relating to their health and safety were managed.

Systems and processes were not in place to find out the experiences of people who used the service, and to evaluate these with a view to take action to continually improve.

Regulation 17 (1) (2) (a) (b) (c) (e) HSCA (RA) Regulations