Care UK Community Partnerships Ltd

St Vincents House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was conducted on 26, 27 and 30 October and 3 November 2016. At our previous inspection on 7, 8 and 15 March 2016 we found the provider was in breach of two regulations of the Health and Social Care Act 2014. There was a breach of Regulation 11 in relation to the provider not ensuring that care was provided with the consent of service users in accordance with the Mental Capacity Act 2005, and a breach of Regulation 17 as the provider had not maintained an accurate, complete and contemporaneous record in respect of each service user. The provider sent us a plan following the inspection setting out how they proposed to address these issues. We carried out this inspection to check that improvements had been achieved and sustained in line with the provider's action plan. At this inspection we found that satisfactory progress had been attained in relation to the provider ensuring that people's care and treatment was provided in a manner that took into account their capacity to give consent. However, we did not find consistent evidence to demonstrate that sufficient improvements had been achieved with the quality of record keeping for people who use the service.

St Vincents House is a 92 bedded care home with nursing for older people, and there were 72 people using the service at the time of the inspection. The service is divided into four separate units and provides care and accommodation for older people with general health care needs and older people living with dementia. Accommodation is provided over three storeys and the building is served by a passenger lift.

At the previous inspection we noted that the provider had appointed a new permanent manager, who has subsequently been confirmed as the registered manager of the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered provider, 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.

People told us they felt safe with staff and systems were in place to protect people from abuse. The provider had supported staff to confidently increase their understanding about whistleblowing so that they understood how to protect people through reporting poor conduct in the workplace.

Recruitment practices were thorough and there were sufficient numbers of staff deployed to meet people's needs. Comments from people, their relatives and staff, along with our own observations, indicated that staffing levels would need to be closely monitored as and when more people move into the service. Staff were provided with the training and support they needed to effectively carry out their roles. They had been provided with training about how to maintain accurate record keeping to demonstrate that people were given the level of care and support they needed, and the provider was committed to continuing to support staff to achieve this.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on our findings. DoLS are in place to protect people where they do not have capacity to make decisions and where it is necessary to restrict their

freedom in some way, to protect themselves or others. The provider demonstrated that people's capacity was assessed where necessary and the principles of DoLS were understood and correctly applied.

Systems were in place to consult with people about their food choices. A range of home cooked foods was produced to accompany the meals provided by the external catering company. People told us that they were suitably supported to meet their health care needs and the provider had worked with local health services to address concerns about the quality of documentation sent by care home staff to local hospitals when people were admitted for inpatient care. Measures were in place to make sure that people were safely supported to take their prescribed medicines.

People were provided with a comfortable and homely environment, which offered facilities for getting together with visitors or quietly enjoying the ambience in one of the small lounges decorated with reminiscence items. The provider had established links within the local community so that people could join in with a wider range of activities if they wished to. We saw many examples of positive interactions between staff and people, and people and their relatives told us staff were kind and friendly. Although staff had a clear understanding of how to promote people's entitlement to respect, dignity, privacy and confidentiality, we noted some issues that needed to be addressed to ensure people received a consistent service that embedded these values.

The written responses for complaints needed to demonstrate the empathy that people and relatives felt was otherwise offered by the management team at the service. Regular checks were carried out by the provider to ensure that people received appropriate care and support to meet their needs.

We found a continued breach of regulation in relation to good governance. You can see what action we asked the provider to take at the end 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 always safe.

Staff understood how to protect people from abuse and plans were in place to mitigate risks to people's physical and social wellbeing, however people did not always have sufficient information to visually identify individual staff caring for them.

Staffing levels met the current needs of people and needed to be closely monitored by the provider if more people moved into the service.

Systems were in place to safely manage people's medicines.

A comfortable and generally hygienic environment was provided, although there were issues with clutter and dust in parts of the premises not used by people.

Is the service effective?

Good

The service was effective.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Staff were supported to carry out their roles with the provision of appropriate training and development, individual supervision and opportunities for group support.

Arrangements were in place to meet people's nutritional needs and seek their views about the quality of the food service.

The provider liaised with external health professionals to meet people's needs and engaged with hospital services to achieve improved outcomes for people during hospital admissions.

Is the service caring?

Requires Improvement

The service was not always caring.

Although some positive measures were in place to promote

people's dignity and maintain their confidentiality, areas for improvement were identified.

The practices for providing end of life care needed to be reviewed to ensure that sensitive and sympathetic support was consistently given to relatives and friends.

Thoughtful and pleasant interactions between staff and people were observed.

Information about people's individual interests, routines and wishes were sought and utilised for planning their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care and support records did not contain sufficiently accurate records to demonstrate that people's needs were properly assessed and met.

People were provided with a range of activities to meet their interests and provide social stimulation.

Complaints were responded to but did not always reflect an openness, and professional warmth and empathy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had a registered manager in post, who was well supported by a clinical lead.

Relatives and staff expressed that some encouraging improvements had been achieved since the previous inspection; however some staff needed more guidance to understand protocols within the service.

Systems had been established to monitor the quality of the service provided and seek the views of people and their supporters.

St Vincents House

Detailed findings

Background to this inspection

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

This inspection was carried out on 26, 27 and 30 October, and 3 November 2016. The first day and the weekend visit on 30 October were unannounced, and we advised the provider we would be returning on the other two days. The inspection team consisted of three adult social care inspectors, a specialist professional advisor with a background in nursing 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. The expert by experience had experience of caring for older people.

Before this inspection we looked at information held by the Care Quality Commission (CQC) about the service. This included the previous inspection report from March 2016 and statutory notifications of significant incidents, which the provider is required by law to report to us. We contacted the local authority safeguarding team and Healthwatch Central West London to acquire their views.

During the inspection we spoke with 16 people who use the service and 17 relatives and friends, and observed how people were supported by staff in communal areas. Some of the people who use the service were living with dementia and were not fully able to tell us their views and experiences. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us. We also spoke with 14 care staff, eight registered nurses, a housekeeping supervisor, a laundry assistant, an activities organiser, an administrator, the maintenance person, the chef, the clinical lead, the registered manager and the regional manager.

We received comments from five health and social care professionals in regards to the quality of care provided at the service.

Requires Improvement

Is the service safe?

Our findings

People who use the service told us they felt safe. Comments included, "I have no problem with staff. I feel safe" and "Staff look after me well, I'm alright with them." One relative told us they thought their family member was provided with safe care which met their complex heath care needs. They informed us that they visited daily and sometimes at different hours and had always observed safe care, "His/her life is in their hands and I feel he/she is very safe here."

Records showed that staff had received safeguarding training. The staff we spoke with were able to explain how they would identify different types of abuse and stated they would inform their line manager if they had a concern that a person was at risk of abuse or neglect, or if they had witnessed any abuse. At the previous inspection we found that although most staff we spoke with were aware that there was a whistleblowing policy, they had demonstrated a low level of understanding about the meaning of whistleblowing or any protections that would be offered if they raised any concerns about the service. At this inspection we found that staff presented a more comprehensive understanding in regards to the provider's whistleblowing policy. (Whistleblowing is the term used when a worker passes on information concerning wrongdoings). We noted that information was displayed about safeguarding and whistleblowing in the clinical staff areas on each unit and the minutes of staff meetings evidenced that these topics had been discussed. Therefore staff could now potentially feel more confident about reporting any concern about any observation of inappropriate conduct by a colleague, in order to ensure people received safe care.

Staff wore different uniforms according to their roles, which enabled easier identification by people and their visitors. We had observed at the previous inspection that most but not all staff were observed to have been wearing name badges, which could have impacted on people's ability to accurately report any concerns about the conduct of individual staff. At this inspection we observed that a significant number of staff were not wearing name badges, which we brought to the attention of the registered manager.

People's care and support plans showed that risks to their health and wellbeing had been identified, for example risk of falls, developing pressure ulcers, malnutrition and choking. Care plans to address and reduce identified risks had been developed, which were kept under review. We found Personal Emergency Evacuation Plans (PEEP's) in people's care plans, which is a bespoke 'escape plan' for people who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of an emergency.

We noted at the previous inspection that staff had expressed their concerns that the staffing levels would not remain adequate if and when the service approached full capacity again, unless appropriate staffing increases were made by the provider. The service had a capacity to provide care and accommodation for up to 92 people and there were 72 people using the service at the time of this inspection, a slight increase since the previous inspection when there 69 people. Comments from people using the service and their relatives were mixed but several people stated they noticed a negative impact on the quality of care and support when staffing numbers decreased, for example if a staff member was off sick and attempts to replace them had been unsuccessful. People using the service and their relatives told us, "There are plenty of staff when I

visit in the late morning", "There is not enough cover. They are always short of staff. There is meant to be four staff for 19 residents but there are always fewer because there is training or someone has gone to hospital", "Not enough staff. Afternoon is better but I sometimes have to wait a long time in the morning for help with underwear", "There are enough staff" and "They are all very kind but there are days that people don't turn up for work and things go wrong. Staff are overworked and underpaid." We asked people and their relatives where applicable, if they had to wait an unacceptable length of time after using their call bell to request support from nurses and/or care workers. Responses included, "Staff come fast when you use the call button", "I mostly use it at night if I use it. Someone comes quite fast", "There's always someone around in the day but at night there is often a half hour wait" and "I know when to ring and when not, don't bother in the morning."

One staff member told us that although they felt positive improvements were taking place in relation to some aspects of the service, their biggest issue was the staffing levels. They told us that there used to be five care workers on their floor but this was reduced to four care workers after the provider implemented restrictions on admissions and the number of people using the service subsequently decreased. The care worker thought there were plans to further reduce the number of staff to three care workers and commented, "We can just about manage but we don't get breaks and there isn't time for everything as everything takes longer." Another staff member confirmed they had been told that staffing numbers could be reduced, "They want to reduce it to three care staff, we won't be able to give people their care on time. They do tell us to go for breaks, but we are here for the residents." A member of the night staff said, "At night at present it is fine and we have a good staff team but it would be a struggle if we were at full capacity" and a relative described the care their family member received during our inspection visit on a weekend evening, "The care is fine at weekends, nothing is bad and the care is no different to the week. The carers are very friendly and they are all good. They work very hard."

We stated in the previous inspection report that we were not able to determine if people's needs would continue to be safely met as and when the number of people living at the service continued to increase. Our observations throughout this inspection, in combination with the views expressed by people, relatives and staff, indicated to us that people would experience longer delays in receiving the care and support they required to ensure their safety and wellbeing if any measures were implemented to decrease staffing levels, but the number of people using the service remained constant or increased. We observed that the provider was using several agency staff, particularly when we inspected at the weekend. The registered manager and the regional manager informed us that the use of agency staff was steadily reducing as bank staff took on shifts and some permanent full and part-time staff requested overtime. We were informed that at the time of the inspection three new staff were awaiting the final stage of their recruitment and the provider was seeking to fill three care worker vacancies.

There were robust recruitment procedures in place to ensure staff had the necessary checks before starting work at the service. All of the files we looked at had a document checklist in place confirming which records had been seen. There was an application form and interview record, which evidenced that candidates were given questions and scenarios to ascertain their knowledge, experience and approach. Each file had two references in place which had been verified and there were documents to demonstrate proof of identity and address, and right to work in the UK. We noted that when the provider had a concern about one staff member's right to work in the UK the staff member was suspended until they could produce the relevant documentation. Disclosure and Barring Service (DBS) checks had been carried out. The DBS identifies prospective employees who are prohibited from working with vulnerable adults and children and informs the provider of any criminal convictions logged against the interviewee. Systems were in place to ensure that staff practicing as qualified nurses evidenced that they held current registration with the Nursing and Midwifery Council.

We observed that medicines were safely stored, administered and disposed of. We saw that nurses wore a red tabard to indicate that they should not be disturbed when they were supporting people with their medicines, and people were assisted in a patient manner. The medicines were ordinarily stored in the clinical rooms on each floor, which were equipped with a digital lock. All medicines cupboards were locked and attached to the wall. We noted that the temperature records for the medicine fridges were up to date; however, we found that one medicine fridge on the first floor was inappropriately being used to store a yoghurt. Records demonstrated that daily checks were carried out to count and check the controlled drugs and records were in place to demonstrate that medicines no longer required were subject to safe disposal. However, there did not appear to be sufficient disposal boxes for the excess medicines collected every month by a specialist contractor. Systems were in place for the clinical lead to monitor how nurses completed the medicine administration record (MAR) charts and any gaps on MAR charts by members of the nursing team were recorded on a handover sheet and given to the clinical lead for their scrutiny. The provider's medicines' policy stipulated that the GP service needed to be informed if there were three gaps or more on a MAR chart. This system enabled the provider to closely monitor whether people received their medicines in line with the prescriber's instructions.

At the previous inspection parts of the premises had been refurbished and we noted at this inspection that the refurbishment of communal areas was completed. The service was appropriately warm and free from any malodours. There was a homely appearance and one person told us about their first impression of the premises when they viewed it before moving in, "it was clean and pretty, it shocked me with its beauty." The relative of another person said, "They come every day to clean the room, it is always spotless." We observed that the parts of the premises used by people and their visitors were clean, but we discovered thick layers of dust on high level pipes in the laundry room. On the first day of the inspection we found an unoccupied bedroom was being used for storage and a COSHH (Control of Substances Hazardous to Health) equipment room contained boxes stored on top of each other and items for disposal, including a television set, which sat next to new pillows. This cluttered room was next door to a utility that provided electricity, which might have caused a hazard.

Suitable infection control protocols were in place to protect people from the risk of health care associated infection. Staff we spoke with were familiar with the provider's infection control policy and we observed that hand rub was available throughout the home and deep cleaning of bedrooms took place when a room became vacant. Staff confirmed that they had access to personal protective equipment including disposable gloves and aprons. We observed that systems were in place for the safe storage and laundering of soiled linen, and the sluice rooms were kept locked when not in use.

We looked at a range of health and safety checks that were carried out by the maintenance person to ensure people were provided with a safe environment. These checks were up to date and included the maintenance of hoists, quarterly fire drills, monthly water temperature checks, annual portable electrical appliances testing, the annual inspection of the electrical installations, the annual landlord's gas safety, weekly fire alarm points testing, professional maintenance of fire extinguishers and weekly safety checks for windows and window restrictors.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 people lack capacity to make 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 Deprivation of Liberty Safeguards (DoLS). At the previous inspection we had found evidence to demonstrate that there was some understanding of the principles of the MCA and best interests meetings among nursing and care staff, who had received training about this topic. However, we did not find satisfactory evidence of mental capacity assessments in the care plans we viewed. We also found that although DoLS applications were being made, the needs of people who used the service as indicated in their care files had suggested to us that there were potentially more people living at the service who could meet the criteria for DoLS. There was also limited written evidence to demonstrate that people, or a representative with appropriate lasting power of attorney status, had been consulted in order to give their consent to the care and treatment in the care files we reviewed.

At this inspection we found the provider had taken satisfactory action to address the issues we had previously identified. People told us they were asked for their consent and a relative said, "I've got Lasting Power of Attorney and they have always involved me in all the important decisions." We observed in one person's care plan that an urgent authorisation was granted for a DoLS application, but it had expired in September 2016 and there was no record of any further follow up. We discussed this finding with the registered manager, who evidenced that he was active in his liaison with the local authority in relation to DoLS applications. Records demonstrated that 'best interests' meetings were arranged in appropriate circumstances to ensure people's rights were protected.

Most people and/or relatives we spoke with told us they or their family member received the care and support they needed from staff who had the right skills and knowledge to meet their needs. Comments included, "You can see the staff know what they are doing and are well trained", "I think the care [for my family member] is ok" and "We came to a multi-disciplinary meeting here last week, it gave us reassurance about how they are treating [my family member's] health care needs." We met a relative who was experiencing a number of problems with the care and support staff provided for their family member; therefore we sought their consent to discuss these issues with the regional manager so that prompt actions could be taken to address their concerns.

Staff told us they felt well supported with their training and development needs. One staff member told us, ""I do get the training, even though I work nights. They cover my shift when I need to do training in the day. They never did that before" and another staff member spoke positively about the support and guidance they received at weekly care worker meetings, "It's really good that we can bring up issues that we have with residents and work place issues." A third member of staff said, "I have supervision every three to six months I think and it is always one to one. I'm happy with my input, it lasts about 15 minutes."

Records demonstrated that staff received formal supervision approximately once every three months and an annual appraisal system was in progress. The staff training matrix evidenced that staff attended mandatory training and other training that was applicable to the health and social care needs of people who use the service, for example training to support people living with dementia and training about the prevention of pressure ulcers. We noted that there were some gaps with individual staff members' training; however, the provider's own monitoring system identified this information so that actions could be taken to ensure that staff complied with their compulsory training programme.

People were generally satisfied with the quality of the food service. Comments from people included, "Meals are ok and fill you up. You get options"; "I get the food I like. I can get tea and biscuits between meals, if you ask for it", "Maybe not what I was used to. You do get a choice though", "Food is nice", "Meals can be very late. Lunch used to always be 12:15, but now it can be 13:30" and "Food is ok. You get two choices of mains." A relative told us that the food was of an acceptable standard but sometimes there weren't enough 'plain English' choices that their family member favoured and another relative said, "They support him/her with feeding. He/she has lost weight recently so they have been giving him/her porridge and fortified drinks and milkshakes."

We spoke with the chef about how the catering service provided for people. The chef explained how the main kitchen at the premises worked in conjunction with an external catering provider. Breakfast was cooked on site, along with homemade soup. We noted from the menu plan that there was a different soup served each day for lunch and supper. The staff in the main kitchen also made sandwiches and cakes, with lunches and suppers delivered to the premises by the catering company. We observed people eating their breakfast on the first day of the inspection and noted that several cooked items were available, for example bacon, sausages, and scrambled and poached eggs. Each person had their own individual nutritional action plan, with information about their dietary needs and preferences. The chef was aware of the nutritional needs for people we had met at the service and was able to provide us with a detailed account of people's needs, for example whether their food needed to be prepared to a specific consistency, fortified to provide additional calories, suitable for a diabetic diet, Halal, vegetarian and/or gluten free.

There were separate winter and summer menus and each seasonal menu cycle operated for three weeks at a time. People were provided with a daily meals choice and feedback forms were available for people and/or their relatives to complete. Completed forms were reviewed by the chef, who also attended residents and relatives meetings to hear people's views. The chef informed us, "I have an open kitchen and I'm happy for people to come down and discuss with me any issues they have or anything that they might like." The main kitchen catering team were able to accommodate requested meals if people didn't like the available choices from the external catering company. We noted that people could request salads, pies and vegetables, and omelettes.

During the inspection we observed two morning and two evening handovers in order to check if there were effective systems for communicating about people's needs and any significant changes that occurred during the course of a day or night shift. We noted that detailed handovers took place, which demonstrated that staff had an appropriate understanding of the needs of the people they were providing care and support to. The staff nurse went through each person in turn and gave an overview of their needs and described if any issues had occurred. They discussed people's wellbeing, nutrition, medicines, health care needs, activities and sleeping patterns. Staff were knowledgeable about the people they were discussing and colleagues raised follow up questions about issues identified. For example, one person was described as having been in a low mood during the night shift and day staff highlighted that they had been fine on the previous day. For another person, staff discussed what techniques could be used for supporting the person when they displayed behaviours that challenged. We also observed that actions had been followed up. A nurse had

noticed during the night shift that a person had a bruise. They had taken a photograph and completed a body chart. The day staff took responsibility for ensuring the person received an assessment by the GP who was visiting that day.

We received some positive comments from people, their relatives and a medical professional in regards to how the provider understood and addressed people's health care needs. One person commented, "I feel fine. They ask if I am in pain and offer me painkillers. I can see the doctor whenever I need to." One relative told us they were pleased with the actions that staff were taking to prevent their family member from developing pressure ulcers, another relative praised a staff nurse for spending an hour on one occasion to fully explain their family member's health care needs and a third relative told us, "The doctors are lovely, I am happy with the medical care." The GP visited the service twice a week and a Consultant for Elderly Medicine visited once a week. A medical professional told us that from a clinical perspective, nursing staff were prompt in recognising and informing medical professionals that they had concerns and instructions were followed correctly most of the time. It was felt that the system worked well when people were cared for by nursing and care staff that knew them well and communication issues occurred when non-permanent staff were on duty. The medical professional stated they had observed kind interactions between staff and people. We spoke with a health and social care professional about some concerns earlier this year in relation to the quality of the documentation sent by staff to local hospitals when people were sent in for emergency health care reasons. The health and social care professional confirmed that an extensive level of work had been undertaken with the service to improve their written communication with hospital services.

Requires Improvement

Is the service caring?

Our findings

People and their relatives predominantly spoke favourably about the caring and friendly approach of staff. Comments from people who used the service included, "It's fantastic here. The staff will do anything for you and nothing is too much trouble. They go out of their way and will do anything", "Staff are nice, they look after us well" and "Staff are very nice and good carers." Relatives remarked, "They always check up on him/her, he/she has regular visits and staff are always popping in, they offer me tea and coffee, even breakfast" and "They respect his/her dignity. They always ask me if I wouldn't mind popping out when they wash him/her. They change him/her on a regular basis too."

Throughout the inspection we observed a number of kind and caring interactions between staff and people who used the service. We saw that staff were patient and carried out care and support for people in the communal areas in an unhurried way. During one of our lunchtime observations, we were informed that it was one person's birthday. Staff were aware of this and individually came over to greet the person with good wishes and give them a kiss on the cheek. We saw the person had a big smile on their face and enjoyed the thoughtfulness shown by staff.

However, we met a member of staff who did not demonstrate a caring and compassionate attitude during our conversation with them. The staff member approached us on one of the units and asked if we were looking for people who could talk with us. They informed us that a member of the inspection team had previously visited the unit on an earlier date and spent time speaking with people who were living with dementia and did not have capacity. They asked us why we would wish to speak with people who did not have capacity and continued to tell us which people with capacity we should speak with, and who we shouldn't speak with as they did not have capacity. We discussed this occurrence with the registered manager and the regional manager.

We found that the refurbishment programme had created new areas within the premises that were designed to promote people's independence, dignity and social wellbeing. For example, there were spacious areas that people could share with their visitors including a café room and a conservatory that overlooked the garden. Relatives and friends could make hot and cold drinks and there was additional space for young children to play, which enabled different generations within families to plan visits that were more pleasant and relaxing for all parties. There was a multi-faith prayer room that people could use to meet their spiritual needs or use for quiet reflection. There were also small lounges on each floor where people could sit on their own if they wished to, or use to have a chat with a friend or relative. However, we found these rooms did not appear to be used during the inspection.

People were asked about their food preferences, routines, interests and whether they wished to be supported with their personal care by same gender nursing and care staff. This information was recorded in people's care and support files and relatives confirmed they had been asked about their family member's current wishes and interests and their life history, if the person was not able to discuss this due to their health care needs. We observed that staff knocked on people's doors and waited for an answer before they entered their bedrooms, which showed they understood people's entitlement to privacy. However one

person told us they were kept awake at nights by staff speaking loudly or arguing in hallways in a language other than English, which they said happened at approximately 5am. Two staff members told us that some staff were known to use their first language. They said this had been raised with senior staff but this behaviour continued.

Staff we spoke with understood their responsibility to make sure that people's confidentiality was maintained. Computer information was password protected and all permanent staff who were required to update people's electronic records had their own password. However, we observed that an agency nurse had been provided with a generic username and password, which was visible to visitors on a noticeboard. This accessibility could have compromised the confidentiality of people's records.

We spoke with one person who was receiving end of life care at the time of the inspection, and spoke with another person accompanied by their relative. Both people had been assessed by the visiting palliative care nurse from the local hospice. The first person told us they were comfortable. The relative of the second person expressed concerns about the quality of the person's care, which was referred to the regional manager. Following this inspection, we received information from the relative to inform us that they experienced additional distress following the death of their family member, as an agency nurse did not know how to support the relative to make necessary arrangements. This resulted in the relatives not receiving sensitive and sympathetic service at a very difficult time. We discussed this with the regional manager, who outlined to us the appropriate actions they proposed to take.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we found that it was not always easy to track the delivery of care over a period of time as some care plans were not clear in relation to whether a health care need was current or resolved. We had needed to speak with staff to determine if a person was still catheterised and if another person had a pressure ulcer. We had found an example of where a pressure sore had not been well documented to demonstrate how the provider responded to people's needs. Checks conducted on people's repositioning charts showed that four people's charts did not indicate the frequency that repositioning was required, one chart had not been completed for 10 hours and on another day several charts had no entries of the care delivered for seven hours. We had found that the above issues in regards to record keeping meant that the provider could not demonstrate that people's needs were responded to in accordance with their individual care plans.

At this inspection we found examples of inaccurate record keeping within people's care plans. The first care plan we looked at contained an out of date and incorrect score for the Malnutrition Universal Screening Tool (MUST) assessment and no night time repositioning was recorded on the person's repositioning charts for two nights. The second care plan showed that the clinical lead had advised nursing staff to commence a daily fluid balance chart and a daily food chart on the previous day but staff had not actioned this. The third care plan we looked at contained an inaccurate age for the person and did not evidence that any actions were taken when the person did not achieve their daily fluid intake level on three days. There was conflicting written guidance in relation to the daily fluid target level in order for the person to achieve hydration. The care plan stated the person had a grade one pressure ulcer but discussions with the clinical lead confirmed that this was not correct. The fourth care plan stated that a person needed to be repositioned every four hours but a separate skin assessment stipulated that repositioning should take place every two hours. We noted that the person had not achieved their target fluid intake level for 18 days in one month but there was no record of what action had been taken.

The above issues in relation to accurate record keeping meant that the provider could not demonstrate that people's needs were responded to in accordance with their individual care plans. This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

We received variable remarks from people and their relatives about whether staff responded well to their needs. Comments included, "I have never seen my care plan. They don't consult me or my relatives about it", "The care is ok", "[My family member's] care is being done well, there are no complaints", "I would recommend this home to anyone, they look after him/her so nicely" and "Things are constantly going wrong with trying to get basic care for [my family member]."

People's needs had been assessed prior to their admission to the service, to make sure that their needs were properly identified. These assessments were carried out by a range of health and social care professionals and the majority of people were admitted to the service straight from hospital or following a stay at another care home. The provider utilised these multi-disciplinary assessments for developing people's care and support plans, in conjunction with a variety of assessments and risk assessments conducted by nursing staff

when they moved into the service.

At the previous inspection people expressed mixed views about the activities and entertainments offered by the provider. Some people had told us they were often bored and would like a wider range of activities. At this inspection people and relatives commented, "I love activities, I do! Especially a chat and a game of cards", "There are no activities", "I don't like to join in activities" and "I like the church service and singing hymns together, and listening to music in my room." Two health and social care professionals told us the activities schedule needed to be more creative in order to reflect people's individual interests and needs. We were told that there was a trend for arranging group gatherings such as tea parties or sitting out in the garden with ice-creams, but there did not appear to be a visible activity taking place during these gatherings, for example a quiz or reminiscence session.

There were three activity staff employed at the service, two staff worked full-time and one of the team worked three days a week. People using the service were provided with a copy of the weekly activities schedule and the activities staff completed daily records to demonstrate which activities people participated in. An activities organiser told us the team did not usually work at weekends unless there was a planned event, for example a garden party or barbecue. We were advised by the activities organiser and the registered manager that there was a plan to introduce a schedule of structured activities at weekends, and the provider was currently recruiting for another member of the team. The activities organiser told us that they tried to spend 10 to 15 minutes every day with people who were bedbound, talking with them and/or using sensory equipment. The team hoped that the appointment of a new activities organiser would enable people to benefit from more individual and group opportunities for social stimulation. The activities organiser informed us that the registered manager was supportive, "He listens to us and always tries to help. He has given us the go ahead to have a three month trial for a 'Power Plate' (muscle stimulation activity) to see if it has a positive outcome for residents."

The provider had established a positive relationship with the local Anglican church, which is located within short walking distance of the care home. Representatives from the church visited every week for a coffee afternoon and a religious service was held once a month. A priest from the nearby Roman Catholic church visited once a week. Since the previous inspection the provider had introduced weekly 'pet therapy' and people could meet the visiting dog in a communal area or their bedroom. The activities team had fundraised in order to purchase a chicken coop which was delivered on the first day of the inspection and we were told that the chickens would be arriving soon. We saw there were a number of rooms available throughout the building for people to enjoy activities in or use for relaxation; however we only saw the café used for a Harvest Festival service and a birthday party. There was a cinema room which had been recently renovated which was not in use throughout the inspection. During our weekend visit we found that the café room was locked and a nurse working on the same floor told us the room could only be used if a person and/ or their relatives had booked it in advance. We discussed this finding afterwards with the registered manager and the regional manager, who advised us that this amenity was meant to be available at all times for people and their visitors to use.

We noted the provider prominently displayed information about how people, and their relatives and friends, could make a complaint. This information was also contained within the Service User Guide and there were details about how to escalate the complaint if people were not satisfied with the provider's response. We reviewed four formal complaints and noted that two of the responses lacked empathy and understanding. For example, one of the responses to a complainant (a relative) stated that staff were fulfilling their responsibilities but specific difficulties arose due to the behaviours of the person using the service. We thought this statement could have been accompanied with reassuring and comforting words about how staff would continue to fully support the person and endeavour to find ways to ensure their wellbeing. One

relative told us about their experience of receiving a written response to their complaint which did not provide the level of detail, sensitivity and professional openness that they anticipated. We discussed this with the regional manager, who appropriately responded to the matter. The registered manager told us that he responded to verbal complaints that people made, by investigating their concerns and reporting back to them verbally. We have advised that these complaints should be recorded in the complaints log so that the provider maintains a comprehensive overview of complaints, in case of any emerging trends. A relative told us that the registered manager had looked into a concern they had raised verbally and they were entirely satisfied with how their concern was dealt with and resolved.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection the service was being managed by a peripatetic manager and the newly appointed manager was in the process of receiving his induction training. At this inspection the registered manager had been in post for approximately seven months. Most people told us they thought the service was managed well and they found the registered manager "approachable", "helpful" and "friendly." One relative stated, "[The registered manager] inherited a lot of problems. He is a very pleasant chap and trying very hard, he walks down the corridors and says hello."

Most of the views expressed by staff were positive in regards to how they were supported by the registered manager and senior staff to carry out their roles and responsibilities. Comments included, "It is one of the nicest homes and it is a good place to work. If we need something, [the registered manager] does listen and get it for us", "The changes have been a bit of a struggle but we are trying to adapt to change. I think [registered manager] has been brilliant in helping the team adapt" and "I do feel comfortable approaching the manager and am confident that things will be sorted out. [The clinical lead] is really good too. There is a lot to do but they know what they are doing."

A staff member told us, "I feel well supported by them (the registered manager and clinical lead) as they are on call on a rota system, so they can advise us if there is a concern." Other staff told us the on call system was "ad hoc" and some staff were not sure who was the allocated on call senior person when we inspected at the weekend. One staff member said they always contacted the clinical lead, who was described as being supportive and always contactable.

A staff member told us they had observed how the service had changed since the previous inspection and how they had noticed improvements, "I will say it is much better now. The paperwork has doubled and we need to record more things on the monitoring charts now." However, some staff members told us that specific changes hadn't appealed to all of the nursing and care team. For example, staff now worked across different floors rather than having an established unit that they were allocated to for several weeks or months at a time. This meant that some staff did not know where they were allocated for that day's shift until they arrived at work. The registered manager explained that this system was introduced for a few reasons, including the need to ensure that the provider had a flexible workforce with the knowledge and skills to care and support people on each unit. We were informed by the registered manager that another reason for this practice was that some units were busier than others, so the new system enabled a fairer distribution of work. However, some staff expressed that this approach did not enable people to receive continuity of care, which they felt could impact negatively on people with memory loss.

We asked several members of staff about the sickness procedure and were told different information. Staff appeared unclear who they should inform if they were not well enough to come to work. Some staff said they should be calling the on call manager and some staff thought they should inform the nurse or senior care worker on the floor they thought they were allocated to. We were told that there used to be a dedicated telephone line for staff sickness; however this had not been in use for at least six months as "no one manned the line." Staff told us they now phoned the main telephone number for the service and whoever picked up

the call was expected to put the caller though to their requested unit. This system was described as being problematic as some staff felt that if an agency worker answered the phone they did not necessarily know how to progress the call. This finding indicated that staff needed additional direction to ensure that there was consistent guidance about how to correctly ring in sick, so that wherever possible prompt arrangements could be made to book a replacement worker to ensure people received suitable care and support. This potentially could also assist the staff team to carry out their duties with the support of the right staffing levels and skill mix.

There were procedures in place to monitor the quality of the service, which included regular audits. We noted the provider had carried out detailed audits of care and support plans, with a specific focus on whether staff were maintaining accurate records to demonstrate that people were receiving safe and appropriate care. These audits were accompanied with staff training sessions and meetings to discuss methods to improve record keeping. We saw evidence that other audits had been conducted since the previous inspection, for example a medicines audit and an infection control and prevention audit. Records showed that root cause analysis exercises were undertaken when people developed pressure ulcers, to enable the provider to evaluate whether improvements could be made with the prevention and/or treatment of pressure ulcers.

Records showed that the registered manager maintained records relating to accidents and incidents, which were checked by the provider to ascertain if there were any patterns of concern that needed to be addressed. The Care Quality Commission was appropriately notified of any events at the service that the registered manager was required by legislation to inform us about.

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	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	You are failing to establish and operate systems effectively to maintain securely an accurate, complete and contemporaneous record in respect of each service user,

The enforcement action we took:

We issued a Warning Notice and required the provider to become compliant with the regulation by 31 January 2017.