Lancam Care Services Limited

Albany Park Nursing Home

Inspection report

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Tel: 02088041144

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11 June 2018
12 June 2018
13 June 2018
19 June 2018
21 June 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Albany Park Nursing Home provides nursing care and accommodation for a maximum of 43 older people, some of whom are living with dementia. At the time of the inspection the service was supporting 42 people.

Our last inspection took place on 11, 12 and 14 July 2017 and the home was rated as 'requires improvement'. However, over the last several months prior to the inspection we had received multiple concerns regarding the quality of care, safety of people, staffing and environmental issues. Due to these concerns we decided to inspect the home earlier than originally scheduled.

This inspection took place on 11, 12, 19 and 21 June 2018. On 11 June 2018 we conducted an early morning visit, arriving at 6.10am. On 19 June 2018 we completed an evening inspection at 8.45pm to look at some specific issues. We provided feedback to the manager on 21 June 2018. On the 13 June we contacted relatives to gain their feedback.

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. There was no registered manager in place at the time of the inspection. However, a new manager had been appointed and had been in post for one and a half weeks prior to the commencement of the inspection. The manager had applied to register with CQC.

At our last inspection we found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had not sustained improvements made following the last inspection.

People did not always have access to call bells both during the day and at night. People were not always able to summon help if they needed to.

The home was not always clean. Chairs, bedding and flooring was often malodorous with urine and on-suite bathrooms were not always clean. Furniture including bed rails and bedroom side cabinets were in a state of disrepair.

People had been placed at risk of harm as they were able to access staircases. The provider had not addressed this issue despite an incident in September 2017.

There were activities within the home. However, we found that there was insufficient stimulation for people. People that spent the majority of their time in their rooms were often left alone for long periods of time.

Staff were not adequately deployed during meal times to ensure that all people received the necessary support to have a safe and enjoyable meal time.

We received mixed feedback about the food provided at the home. People did not always have easy access to drinks.

Audits completed by the home had failed to identify the issues found at the time of the inspection.

Risk assessments gave staff detailed guidance and ensured that risks were mitigated against in the least restrictive way. Risk assessments were reviewed and updated regularly.

Medicines were managed safely and people received their medicines on time. There were systems in place to audit medicines and identify any concerns.

Staff had access to Personal Protective Equipment (PPE) to ensure that people were protected from the risk of infection.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Staff received regular, effective supervision and appraisal.

We observed some caring interactions between staff and people. However, we also observed some interactions that were not always caring.

Relatives involvement in planning and reviewing peoples care was inconsistent.

People's care files documented that people had access to an advocate to help them make certain decisions if necessary.

People and relatives said that they felt that staff asked for consent when carrying out any care tasks.

There was a complaints process in place and people and relatives knew how to make a complaint. Complaints were investigated and followed up.

We identified breaches of regulations 9, 12, 15 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Some people's call bells were out of reach and people were unable to summon help if required.

Furniture was not clean and there was a strong smell of urine throughout the home.

People were placed at risk of harm due to inadequate safety controls around accessing staircases.

Staff were not deployed in an effective way to meet people's needs.

Risk assessments detailed people's personal risks and provided staff with guidance on how to minimise the risk.

Medicines were safely managed and people received their medicines on time.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective. There were not enough staff available at mealtimes to support people. People did not always have easy access to drinks.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DoLS).

Staff received regular supervision and appraisals. People were supported by staff who regularly reviewed their working practices.

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

Is the service caring?

Requires Improvement

The service was not always caring. We did not always observe caring interactions between staff and people.

Relatives were not always involved in planning people's care or care reviews.

Staff respected people's privacy and knocked on people's bedroom doors before entering.

Staff understood consent to care and the importance of seeking consent before carrying out any care tasks.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were not adequately stimulated and there were insufficient activities available.

Care plans were detailed and person centred.

People and relatives knew how to make a complaint.

There were appropriate arrangements in place for end of life care and people and relatives had been consulted.

Is the service well-led?

Requires Improvement

The service was not always well-led. Audits had failed to identify issues including those we found. Feedback from surveys had not been adequately addressed.

The management structure of the service was unclear.

There were regular recorded staff meetings.

Albany Park 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.

This inspection took place on 11, 12, 13, 19 and 21 June 2018. The inspection was carried out by two adult social care inspectors and three experts 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. One expert by experience attended the inspection and spoke with people to gain their views and opinions of the home. The second and third experts by experience supported this inspection by carrying out telephone calls to people's relatives on 13 June 2018.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We also looked at safeguarding notifications that the provider had sent to us. Providers are required by law to inform CQC of any safeguarding issues within their service.

During the inspection we spoke with 13 staff including the nominated individual, manager, clinical lead, two nurses, the care coordinator, four care staff, the assistant chef, a domestic and the activities coordinator. We also spoke with 16 people and four relatives. Following the inspection, we spoke with a further 14 relatives.

We looked at 10 care records and risk assessments, seven staff recruitment files, 23 staff supervision and appraisals files, 42 people's medicines records and other paperwork related to the management of the service including staff training, quality assurance and rota systems.

Inadequate

Is the service safe?

Our findings

Bedrooms and bathrooms had a call bell system in case people required help. However, we observed that people did not always have access to call bells and would have been unable to call for help if they needed to. We checked people's access to call bells throughout the inspection, early morning, day and night time, and found 17 instances where people were in bed and call bells were either out of reach or not working due to being incorrectly connected. We observed that call bells were under beds, on chairs, attached to the opposite wall where the bed was positioned or placed on the bed where the person would have been unable to reach them due to their lack of mobility.

We observed one person who was bed bound an upper floor calling out for help. There were no staff on this floor and we went to see the person. The person said that they had been pressing their call bell as they needed repositioning and were unable to do it themselves. We informed the nearest available member of care staff on the floor below who came to help. The call bell was checked in the presence of the clinical lead who said that it was plugged into the wrong socket and was not registering when it was pressed. There were no staff on that floor and the person's call bell was not working. This meant that the person was placed at risk of harm as they were unable to summon help.

The home had two staircases either side of the building which were easily accessible from each floor. We saw that there had been an incident in September 2017 where a person had wandered and fallen down the stairs sustaining an arm injury. The incident itself was dealt with appropriately. Following the inspection, the nominated individual told us that they had not been informed of this incident which had led to a failure to recognise and respond to the risk. Access to staircases was a risk and there were no control measures in place to prevent a recurrence of the incident. The day before the inspection we were told that a person had absconded via the staircase which also led to an unalarmed emergency exit. Staff realised that the person had gone missing and they were found within five minutes. For people who wandered or may have been confused, doors to staircases were easily pushed open and there were no safety mechanisms in place to prevent this. This placed people at risk of harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the cleanliness of communal areas, chairs and carpets. Following the inspection, the provider sent us an action plan and told us that they had replaced some chairs with new fabric ones and had the carpets cleaned. At this inspection we found that the provider had failed to sustain these improvements.

There was a strong smell of urine throughout the home. In the communal lounge we found that there were fabric armchairs. The internal seating cushions were wrapped in black bin bags to create a water proof barrier. We found that nine of the 14 armchairs were stained and smelled strongly of urine. We showed the chairs to the manager and the provider who were present at the time. The manager asked the domestic staff

to remove cushion covers to clean them. We further saw that one of the internal cushions had a lot of black mould on it. At the opposite end of the communal lounge was the dining area. Dining room chairs were also stained with food and other stains which required a deep clean.

We observed that ten people's bedrooms smelled very strongly of urine which did not dissipate throughout the inspection. Two people's mattresses were stained and malodorous with urine. The downstairs toilet by the laundry was also malodorous with urine. There were mops and buckets located in the laundry room which were dirty. In one person's on-suite bathroom there was a soiled pad laying on the floor that had not been appropriately disposed of.

Furniture and fixtures were not always maintained or clean. In six people's on-suite bathrooms we found that shower drains were black and dirty with water pooling in the drain. Extractor fans were thick with dust preventing them from working adequately. In one person's room we saw that their curtains were hanging down and not in a good state of repair. Bedrails were in poor state of repair and there were many small cracks which prevented them from being adequately cleaned and maintained. Furniture often had the veneer peeling and cracking off leaving rough edges placing people at risk of injuring themselves. On day two of the inspection we walked around the home with the manager and showed her some of our findings.

Relatives gave us mixed feedback regarding the cleanliness of the home. Positive feedback included, "From what I have seen, both my relative's room and the home in general is very clean", "The home is clean and is looked after well. I looked at the home before mum was admitted" and "The home is very clean." However, other relatives also said, "Sometimes the bed linen are smelly and need changing. I tell them. Sometimes I change them myself. The pillows are not good, they are lumpy", "It's ok, but dingy. The lighting needs changing. The room opposite [relative], there is a strong smell of urine, which I have spoken to the manager about" and "Rooms can have odours. There can be strong smells of faecal matter. They open the windows, it can be quite strong."

This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day three of the inspection the manager told us that the provider had authorised the purchase of new armchairs for the living room which were wipeable and more easily maintained. We were also advised that a daily mattress check has been implemented and a call bell record was now in all rooms.

The provider used a dependency tool which was completed monthly. A dependency tool is a way of looking at people's needs and ensuring that there are adequate staff to provide care and treatment. We saw a dependency tool from May 2018 which showed that the provider had sufficient staff on each shift. However, staff were not deployed in an effective way. For example, on the first and second floors we observed that there were no staff present for long periods of time, despite some people being bed bound on both floors. During the inspection, we observed that during lunch times staff were taking their breaks. In one instance there were three staff on break at this time. This left the home short staffed during a busy period. We raised this with the manager who told us that staff deployment was an issue that she had identified and was in the process of addressing this.

We asked people if they felt safe living in the home. One person commented, "I think I am safe here." Relatives told us, "I think she feels safe here and no harm will come to her from staff" and "On the whole they do a good job." All staff had received training in safeguarding and how to ensure that people were protected from harm and abuse. Staff members that we spoke with were able to explain how they would keep people safe and understood how to report any concerns where they felt people were at risk of harm. Staff could

explain different types of abuse and how to recognise it. One staff member told us that safeguarding was, "We have to make sure that vulnerable adults are protected. I would report it [suspected abuse] to the nurses."

Care plans that we looked at detailed people's risks associated with their health, care and support needs. There was comprehensive guidance for staff on how to reduce risks in order to keep people safe. As well as being documented in care plans, people had detailed risk assessments for each risk that had been identified. Risk assessments were updated monthly or when there was a change in care needs or risks.

Where people were identified to be at high risk of falls there were detailed risk assessments in place with specific guidance for staff on how to minimise the risk. One person was on regular use oxygen to aid their breathing. This has been identified clearly, a risk assessment in place and the person's oxygen saturation level checked and documented every four hours. Other risk assessments included, the use of bedrails, moving and handling, medicines, diabetes, dementia, and continence care including catheter care.

People's potential for developing pressure ulcers was regularly assessed by using the Waterlow scale. The Waterlow scale is a specific way of estimating the risk to an individual of developing a pressure ulcer. Three people had been identified to be at very high risk of developing pressure ulcers. For each person we saw that they were receiving preventive management such as using pressure mattress, pressure relieving cushions and turning charts. Turning charts viewed showed that people were repositioned every four hours at night and during the day if they remained in bed. Pressure mattresses were set to people's weight and checks to ensure that adequate pressure was maintained were documented.

The home used the Malnutrition Universal Screening Tool to assess people's risk of malnutrition. Two people were noted to be at medium risk of malnutrition and were being provided with a fortified diet including food supplements. To ensure effective malnutrition risk monitoring, people's weights were checked every month and weekly if they were at medium or high risk. Where appropriate we saw that people were referred to speech and language therapy for assessment.

Medicines were safely managed and the home used the blister pack system provided by the local pharmacy. A blister pack provides people's medicines in a pre-packed plastic pod for each time medicine is required. Medicines were only administered by qualified nurses and records showed that all qualified staff had completed medicines management training and competency assessments. There were appropriate arrangements in place for recording the administration of medicines and Medicines Administration Records (MAR) were clear and fully completed. Staff ensured that medicines were counted after each administration to check for any discrepancies, gaps in signing or any other kinds of error. The clinical lead also checked at the end of each shift to ensure that nurses had followed good practice.

Staff were observed supporting service users to take their medicines safely. We found that the provider's processes for managing people's medicines ensured staff administered medicines in a safe way. We observed one nurse administering a person's medicines in a professional and compassionate manner without rushing.

Three people received their medicines covertly. Covert administration of medicines is used when a person actively refuses their medicines and is judged to not have the capacity to understand the consequences of refusal. The medicines are often concealed in food or drinks, and requires authorisation of the GP and dispensing pharmacist. Where people's medicines were given covertly it had been clearly documented how the medicine should be given both in the person's care plan and their covert medicines protocol.

The home had appropriate storage for controlled drugs. There was a separate controlled drugs cabinet. Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Controlled drugs were stored appropriately and administered with two staff signing to say that the medicine had been given.

Where medicines were prescribed to be given 'as required' (PRN), or where they were to be used only under specific circumstances, there were protocols in place which were tailored to the individual and provided guidance to staff on how these medicines were to be administered. As required medicines are medicines that are prescribed to people and given when necessary. This can include medicines that help people when they become anxious or require pain relief.

There were two small medicines fridges in the clinical room to ensure that medicines requiring to be stored in fridge temperatures were stored safely and securely. The temperatures of the clinical room and the fridges were monitored daily. Any liquid medicines such as eye drops had been labelled noting when they were opened and when they needed to be discarded.

There were records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. Incidents were recorded in detail and any action taken at the time of the incident had been recorded. The manager reviewed incidents and signed to say that actions had been appropriate. However, outcomes or action following the incident had not been documented.

The service followed safe recruitment practices. We looked at seven staff files which showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role.

Staff understood how infection control processes to protect people. Staff had access to Personal Protective Equipment (PPE) such as aprons and gloves. Throughout the inspection we observed staff using PPE when getting ready to conduct personal care. Relatives commented, "They always wear gloves" and "They wear gloves and aprons and aprons when they serve the food."

Each person's care plan contained a Personal Emergency Evacuation Plan (PEEP) detailing how the person was to be supported and kept safe in the event of a fire or other emergency. There were regular tests of fire alarm systems and fire drills to ensure that people and staff would know what to do in the event of a fire.

The home had up to date maintenance checks for gas, electrical installation, lift maintenance and fire equipment. Staff understood how to report any maintenance issues regarding the building.

Requires Improvement

Is the service effective?

Our findings

We observed two lunch sittings during the inspection. The majority of people ate meals in the communal lounge and some people were served their food in their rooms. People were able to choose where they wanted to eat. However, the dining area was quite small and people were often sitting very close to each other. There were not always enough staff deployed to ensure that mealtimes were well managed. For example, we observed one person ask for some biscuits and the staff member said, "I have to give the tea to everyone first, I'm the only one here." We observed that people that required help with eating were supported by staff. However, due to the staff deployment, people sometimes had to wait for help to eat their meals.

We received mixed feedback regarding the food from people. Comments included, "Cornflakes for breakfast. For supper one slice of bread, meat, fish, chicken, sometimes pickles" and "It's nice." Another person said, "The food sometimes it's alright, sometimes it's horrible. At 2.00pm they come round and ask me about the food. No presentation, dry, I put olive oil over it." Some relatives were positive about the food and told us, "My [relative] is very confused but he is eating much better now and has been putting on weight since he was admitted some six months ago", "Yes, I think the food is good at the home, a good choice every day. My [relative] seems to be well fed, but then he likes his food" and "I think the home feed the residents well. My [relative] has difficulty in feeding as she can only have soft and pureed foods and carers assist her with her feeding." Other relatives were less positive and commented, "They dish him up the food. It looks like slosh and diarrhoea. [Relative] has a problem with his dentures, he doesn't eat much. The burger in the evening did not have any meat in the bun, it only had a piece of processed cheese, tomato and cucumber in it" and "They do their best with the food. They still give her hard biscuits, which she can't eat."

People did not always have access to drinks in their rooms and we saw three instances where people were in bed and did not have ready access to any drinks. A relative commented, "[Relative] is diabetic and gets very thirsty. He is supposed to have a jug of water in his reach and he doesn't." We observed tea rounds during the day for people in the communal area and people in their rooms.

On the first day of the inspection we taste tested the pureed main lunch meal to check that the flavour and consistency was appropriate. Pureed food was presented well with each element being separate on the plate. Food was flavoursome and well-seasoned.

The kitchen was clean and well organised. Fridges and freezers were within correct temperature ranges and checked daily and the kitchen had received a five-star rating from Environmental Health in 2018. Menus were in four weekly cycles and were decided by the head chef in consultation with people. The assistant chef told us that they changed the menu sometimes based on weather. For example, the day before fruit salad had been served for dessert as it had been hot. People were able to ask for alternative meals such as jacket potatoes and sandwiches. The home had several people from the Caribbean and we saw that the menu reflected their cultural needs.

Where people had specific dietary requirements such as pureed, diabetic or any food allergies, the kitchen

received notification forms from the nursing staff which stated these. Notification forms also noted people's individual likes and dislikes regarding food.

Following the inspection, we informed the manager about the feedback regarding food. The manager said, "I'm addressing it, we have a meeting coming up with the residents and relatives to discuss the menu. We have also devised a food sheet for relatives and residents." The manager said that the food sheet would give people and relatives a further opportunity to note dietary likes and dislikes.

Relatives that we spoke with told us that they felt that staff had the training and skills to look after their relative. Comments included, "Yes, I think they [staff] are trained and skilled" and "Yes, on the whole, some carers are better than others."

We looked at the files of five staff who had been employed since the last inspection. We saw that each staff member had received an induction when they started to work. Staff received mandatory training in areas such as health and safety, safeguarding and the Mental Capacity Act (MCA). Staff then shadowed more senior staff before being able to work alone. One staff member said, Yes [induction]. I done training. When I came, I worked with [a] senior to give me more experience."

Staff told us and records confirmed they were supported through regular supervisions. Nurses received regular clinical supervision from the clinical lead. Supervisions were personal to the staff member in question and detailed where things were working well, training needs and if there were any concerns. We saw that where any issues had been identified, such as training needs, this had been followed up and training provided. Staff had all received an annual appraisal in August 2017.

Staff received a wide range of person centred training to enhance their performance such as moving and handling, dementia awareness, diabetes awareness, equality and diversity, infection control, safeguarding and medicines training. Training was provided both face-to-face and on-line. Face-to-face training was provided every two weeks at the home by an external company and covered a variety of topics. A staff member told us, "Every two weeks someone different comes in. Infection control, fire safety and health and safety." Other training such as wound management, venepuncture, catheterisation, syringe driver, end of life and NVQ LEVEL 5 had also been provided to nursing staff. Two staff told us that they felt they had the right skills to perform their role and had been offered training that boosted their performance.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People's care files had mental capacity assessments and records showed that people who lacked capacity to make decisions about their treatment and care had been assessed. There were records of decisions being made in the best interests of people who lacked capacity. A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in

their best interests. Where a person lacked capacity relatives who were able to make decisions on people's behalf for their health and wellbeing had legal authority to do so. Where people required a DoLS, these were in place. There were dates noted for when the DoLS needed to be reviewed. If a person had had conditions as a part of their DoLS that was specific to their care, this had been included in people's care plans.

Where people were receiving covertly administered medicines or using bed rails, this had been done in the person's best interests and a mental capacity assessment completed to ensure that the person lacked capacity to make that decision. There were documented best interests decisions involving the GP, the pharmacist, the home and a relative.

Staff had received training in the MCA and understood how this impacted on the care that was being provided to people. One staff member told us, "Sometimes [people] can't make decisions. They have next of kin, or someone, to make certain decisions. We still ask them. Say what we will do."

When people were referred to the service, records showed that a pre-assessment had been completed. This looked at all aspects of people's care needs and helped form the basis of the care plan in terms of what support people required.

People's care records showed that people had access to various health care services. This included, dentists, opticians and chiropodists. Where any advice had been given, people's care plans had been updated to reflect this. The home worked with the Care Home Assessment Team (CHAT) who visited every one or two weeks. CHAT supported to the home with community psychiatrist nurses, continence nurses, palliative care, tissue viability nurses and other medical support. Nursing staff confirmed that the support of the CHAT team had reduced the rate at which the people living at the home were admitted to hospital for admission. Where people had multiple falls, they were referred to CHAT for assessment.

We saw that the home had received a number of compliments from both relatives and healthcare professionals. Relatives said, "'Thank you for the care. You do an amazing job in a challenging environment" and "Thank you for birthday party. [Staff member's] catering skills are legendary." A healthcare professional said, "Impressed with the care plans. Clear and well laid out."

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback when we asked people if they thought the staff were caring. At 7.08am on the first day, one person said, "I wouldn't say 100% [caring]. Not all of them. There's a lady here who is very caring. She sits me up and washes my face. The night staff used to give me tea in the morning but now that has stopped. Sometimes they do it [make tea during the day] and sometimes I have to beg." The person told us that they had been awake since 5.00am but had not been offered a drink. Other people said, "They don't care here now, they don't seem to. Some [staff] are alright, some are very helpful and some aren't" and "They tell me do this do that. They are not nice. Don't walk here. Don't walk there." Other people said that they felt that staff were kind and looked after them well. One person said that the nurses and carers were taking good care of him and said, "I have got much better, my dry skin has improved and I eat better now because the food here is good."

Relatives were positive about the kindness of the staff and some feedback we received included, "Staff are extremely caring and kind to mum. They certainly respect her and treat her with dignity", "The staff are very friendly, very nice and chat to [relative]. They respect his needs and as he is deaf they have organised a new hearing aid" and "Yes, the staff are very kind and understanding with my mother who has dementia."

When we arrived on day one at 6.10am we found that most people were still in bed and the home was calm and relaxed. People told us that they were able to get up when they wanted to. People's care plans recorded what times people liked to get up and go to bed. People were not rushed to get out of bed.

Throughout the inspection we observed that people who remained in bed during the day were often very isolated and did not have much interaction with staff or people. We spoke with a person who remained in their bedroom did not have a television or any form of stimulation. The person was very distressed and told us that they were, "Always lonely."

We observed some warm and friendly interactions between people and staff. For example, staff knew people well and were talking to them about things they enjoyed. One person was a supporter of a particular football club and staff were talking to him about the up-coming football season. However, we also observed some less caring interactions. For example, at lunch time on day two, two people were sitting in the lounge area and were repeatedly asking for their lunch. Staff were not acknowledging them and talking amongst themselves about whether the two people had been fed. Both people could hear the staff talking about them and one person responded loudly on overhearing the staff, "Has anyone fed me? I only want a few spoons." We intervened and told care staff that neither of the people had their lunch. When the food was served, no cutlery was given and one of the people started to use their hands to eat whilst asking for a fork.

When people were receiving care, we observed that staff spoke with them as they were carrying out care such as hoisting. Relatives told us, "I've seen them hoisting [relative]. They talk to her when they are doing it to make her feel comfortable."

People's personal space was respected. Staff asked people of they were ready to receive personal care in the

mornings and we observed staff knocking on doors and waiting for a response before entering. People confirmed that staff knocked on their doors before entering. Staff understood consent to care and the importance of asking people if they were ready to receive personal care. A relative told us that they felt communication with their relative was positive and commented, "The staff are very caring and friendly and treats my father-in-law with respect and dignity. He has a senior nurse who takes time in communicating with him and he has settled in very well."

We found that relatives involvement in people's care planning and care reviews was not consistent. Care plans that we looked at had documented where relatives had been consulted. However, we received mixed feedback about relative's involvement in planning care. Relatives said, "No really they don't discuss care plan", "I have not seen the care plan here" and "I haven't seen a care plan, I only see things if I request it." However, other relatives that we spoke with were positive about the input they had into planning their relatives care. One relative said, "The [clinical lead] is very good. We talk about it [person's care]."

We asked relatives if they were involved in reviews of people's care. Eight relatives that we spoke with said that they had not been involved in any care reviews. Other relatives that we spoke with told us that they had been involved and feedback included, "I think we had a new plan a couple of months ago" and "We have been invited to attend a review of [relatives] care plan for [this month]."

We asked relatives if they were informed of any changes or issues regarding their relative. We again received mixed feedback. Positive comments included, "Mum has a key worker and she informs me of any changes in her care", "Only on daily things" and "The [clinical lead] is very good and keeps us updated." Other comments included, "The communication is not so good. My [relative] had experienced bad bed sores, falls and a trip to the A&E which we were not informed of" and several relatives said, "Not really."

Where people required an advocate to help with decision on their behalf, this was documented on people's care records. If the advocate was a relative with legal authority this was clearly noted. Where a person had an Independent Mental Capacity Advocate (IMCA) this was also recorded. Care plans documented any choices or decisions made in conjunction with advocates.

Requires Improvement

Is the service responsive?

Our findings

The home employed an activities coordinator and we observed some activities going on throughout the inspection. The activities coordinator told us that there was a fund for activities and people and relatives could make suggestions. We saw that the activities coordinator was enthusiastic and friendly. However, activities were not consistent.

Relatives told us, "There is not much stimulation for people. Only things like bingo and he gets bored. There is nothing going on at the weekends", "The activities are so poor, they have activities am and pm. Apparently, they do drawing and painting, the coordinator does try. At the weekend there is no activities, I take in a quiz book and song sheets sometimes for residents at the weekend", "There has not been any activities when I have visited. The residents mainly sit in lounge and sleep while the TV is on. I have not seen any stimulation" and "There doesn't seem to be enough for residents to do to stimulate them, plus not enough staff to organise these activities."

A person told us, "Do exercise, in the chair, listen to music, sing, karaoke. The activity co-ordinator said gentle exercise is good." Relatives also said, "The activities are really good here, she is always downstairs doing things like bingo, arts and crafts, card making. This helps with her fine motor skills", "My [relative] is usually taken down into the lounge for activities. But she has dementia so is not really interested in anything" and "Oh yes, [relative] loves the Bingo, games and watching TV in the lounge."

Where people were in their rooms during the day we saw that there was very little in the way of activities for them to engage in. A staff member told us, "We try. Before they [people] used to participate and come down. Twice a week one-to-one, Monday and Thursday. It depends on people's moods. We try to see everyone on that day." This meant that people that were unable, or did not wish to be in the communal area were only offered some form of activity two days of the week. A person said, "No I don't do any activity. I can't walk. I stay in my room all the time. I go down for my hair. Nobody comes to see me."

We did observe some activities during the inspection including a quiz and chair exercise. We also observed one activity where a word search was passed around between several people sitting at a table in the communal room. However, people appeared uninterested and due to their dementia did not always understand what the word search was. Whilst this was going on the other people in the room were not engaged and were observed to be dozing or sitting with nothing to do.

The activities coordinator told us that there were occasionally day trips and said, "We have been on day trips a couple of times depending on the weather. We organise a trip to the park. We can't take many, maybe four people as we need a carer per person. We went to the pub and the coffee morning in the church." We did not observe any external activities throughout the inspection. For example, it was nice weather during the inspection and the home had a large outdoor space where people could have sat outside.

There were long periods of time where we observed that people were not stimulated and there were insufficient activities to ensure that people were occupied.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a dedicated hairdressing room and people were able to make an appointment as and when they wanted to. People told us that staff would encourage them and remind them when their appointments were.

The home used an electronic system to document, store and update people's care plans. Each staff member had access to the system and were able to update care plans when necessary. Care plans were comprehensive and person centred. They were tailored around the person and gave a good picture of the individual, which included their personal histories and preferences with regards to their care. One person supported a particular sports team and we saw that the person's bedroom had been decorated with team paraphernalia.

Care plans addressed each care need in a separate section. For example, personal hygiene, moving and handling, medicines, wound care plan and end of life care plans. People's personal well-being was addressed and guidance was clear for staff to on how people's needs should be met. Care plans were regularly reviewed monthly or more frequent if there is any change.

We saw that there had been four complaints documented since the last inspection. We noted that there had not been any complaints raised since November 2017. We were unable to confirm if this was the case as the previous interim manager was no longer in post. For the complaints that had been documented we saw that the complaint had been acknowledged and investigated. There were details of the outcome and how the home had addressed the complaint. For example, lost clothes had been replaced by the home and there had been a meeting with the family.

People, where able, and relatives told us that they knew how to make a complaint if they needed to. Relatives said that they had been given information on how to complain. Comments included, "I have no concerns with this home and I do know how to make a complaint", "Yes I do know how to complain and I never have had to" and "I speak to the owner. I don't want to have to go through a complaints process."

There were advanced care plans in place for people experiencing end of life care. These care plans documented people's end of life wishes and how they wanted to receive care in their final days. Care plans were regularly reviewed by the nursing team. Where people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR), These were up to date and written in consultation with the family member and appropriate health professionals who had also signed it.

Requires Improvement

Is the service well-led?

Our findings

The home completed call bell audits every day between 11.00am and 11.30am. However, most people were out of bed when these checks were completed and were not reflective of whether call bells were accessible when people were in bed and would have needed to use them. There were no checks at night to ensure that people had access to their call bells. We showed both the clinical lead and the manager instances where call bells were not in place.

We saw an infection control audit dated 1 June 2018. The audit had been scored as 'excellent' at 96.6% positive. The audit noted that furniture was of good use and clean and that 'fabrics of the environment' smelled clean and fresh. This was contradictory to what had been observed by the inspection team. None of the issues identified during the inspection had been identified despite the audit having been completed shortly before the inspection.

Accidents and incidents were documented and signed off by the manager. However, there was no follow up to note the outcome of the incident such as, any referrals to other healthcare professionals or if the person had gone to hospital what the outcome had been. Accidents and incidents were not analysed to look for trends.

Staff were not deployed in an effective way to ensure that people's needs were being met. People that were bed bound were often left for long periods of time with no staff available on the floor. At lunch times there were staff taking breaks which led to there being a shortage of staff at busy periods and people's needs not being met quickly. Whilst this had been identified by the new manager, steps to address this had not yet been out in place.

A feedback survey had been carried out in September 2017 which 19 people had responded to. Feedback received from people was similar to issues identified at this inspection. For example, 'rooms need décor touch up, lack of food options, food not diverse and not aware of complaints procedure'. An action plan had been put in place to address issues and a copy of this was seen attached to the notice board at the front door.

The September 2017 survey also received feedback from relatives and healthcare professionals. One healthcare professional had said that the home needed, 'More activities, more residents and relative involvement. More stimulation for residents with cognitive impairment who can't get much from group activity'. Relatives raised concerns in the survey about a lack of communication between the home and themselves, that more menu choices required and they wanted to see more interaction between staff and people that used the service. We saw that communication had been raised at a staff meeting and the menu had been reviewed by the chef. However, the survey had been completed nine months previously and the issues noted were also found at this inspection. The home had not adequately addressed concerns raised by the survey.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The homes last registered manager had left in September 2017. There had been an interim manager who left in April 2018 but had not applied to CQC for registration. The new manager at the time of the inspection had been in post for four working days. Staff and relatives that we spoke with talked of an unstable management structure and a lack of clear direction and guidance. Feedback from relatives included, "Too many changes in management", "The phone is not answered. It rings and rings and rings in the office" and "I have no concerns." People said about the management, "It's never clear who's who" and "If I was the manager I would do a daily round asking are you alright, do you need this or that." People and relatives were aware that a new manager had started.

There were regular medicines audits conducted by the clinical lead and other staff nurses on a daily, weekly and monthly basis. The home's pharmacy provider had also completed an audit in May 2018 to ensure that medicines were managed safely at all times. We saw that there were no actions to be completed from the external audit and medicines were found to be managed safely.

The home also completed three monthly kitchen audits that looked at things like the cleanliness, stock levels and hygiene. There were regular 'Care Audits' that looked at the quality of care, pressure ulcers and end of life care.

Supervisions had been documented and an overview provided which allowed the manager to ensure that regular staff supervisions were happening.

Slings used for moving and handing were audited regularly. We saw that where issues with people's individual slings had been found, new slings had been ordered.

There had been a residents meeting in April 2018. We saw that a barbecue for August had been discussed, people were reminded about the complaints procedure and people had been asked for menu suggestions.

There were regular staff meetings documented, this included meetings for domestic and kitchen staff, care staff and nursing staff. Meetings looked at people's care needs and any concerns or issues. Staff told us that they were able to bring up anything they wished to discuss at these meetings.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care There were insufficient activities to ensure that people were stimulated and engaged.