Country Court Care Homes 3 OpCo Limited

The Burnham Nursing and Residential Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Burnham Nursing and Residential Centre is located in a residential area and provides care and support for up to 54 people over the age of 65 who require personal care and/or nursing care. The home has a specialist unit to provide care for people living with dementia. There were two floors in current use, Sandpiper on the ground floor and Nightingale on the first floor. Both floors had a mix of people, those who require nursing care and those who require personal care. There were 43 people using the service at the time of the inspection.

This inspection was unannounced and took place on 10 and 11 August 2016.

The registered manager had recently left and two temporary managers were in post, having taken over in March 2016. 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.

Most people we spoke with were concerned about staffing levels in the home. Although we observed staff to be rushed and people told us they waited sometimes, they were happy with the care they received and interacted well with staff. Experienced staff had built good relationships with people. The managers had developed links with the community.

Although staff received training, some staff we spoke with did not understand their responsibilities around safeguarding. Staff received training for other topics, such as manual handling, but had not received support via supervision through a time of significant change.

There had been a number of changes in the management team since our last inspection. This had led to a period of inconsistency. Everyone we spoke with felt the new, temporary managers were making positive changes and the service was improving.

People, and those close to them, told us they were not involved in planning and reviewing their care and support after their initial meetings when they moved in to the home. Care staff did not have access to people's care plans because they didn't have access to them, so relied on information being passed to them from the nurses.

People's views on meals were mixed. Cooks had not been made aware of everyone's dietary needs, allergies and preferences. People were not involved in menu planning.

The quality assurance processes in place to monitor care and safety and plan ongoing improvements were not fully effective. There were systems in place to share information and seek people's views about the home. Complaints and concerns were not always used to improve the service. A number of compliments

had been received.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because:
•□people, relatives, visitors and staff all said there were not enough staff,
•□care and treatment was not always provided in a safe way,
•□some people were subject to unauthorised restrictions,
•□staff had not been supervised regularly,
•□people did not received person centred care
•□the quality assurance processes in place to monitor care and safety and plan ongoing improvements were not fully effective.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe, however we found there were days when there were not enough staff to keep people safe.

Although most staff knew how to protect people from the risk of abuse, they were not aware of how to escalate concerns to the local authority.

Risks to people were not well managed. Staff did not have the guidance they needed to keep people safe in emergencies.

Staff did not have up to date checks to make sure they were competent to give people their medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have a clear understanding of the Mental Capacity Act 2005 (the MCA).

Staff were not always aware of people's allergies to foods or where people needed to avoid certain drinks. People's views on the quality of meals was mixed.

People told us staff had the skills to look after them. Staff confirmed they received training for a range of topics including manual handling.

Is the service caring?

Good

The service was caring.

People told us they were supported by kind and caring staff. We observed staff engaging people in conversations which people enjoyed.

Staff respected people's privacy and dignity.

People told us staff gave them choices and supported them to

maintain contact with their families and friends.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were inconsistent. Care staff did not have access to the care plans. People or their relatives were not involved in developing their care plans.

People did not always have access to healthcare professionals when needed.

The temporary managers used complaints and concerns as an opportunity to improve the service. Relatives we spoke with said they could raise a concern if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some quality assurance systems were ineffective to make sure any areas for improvement were identified and addressed.

Everyone we spoke with told us the temporary managers were approachable and were making a difference. They told us the service was improving.

People were supported to access the local community. A variety of community activities were available for people to join in.

The Burnham Nursing and Residential Centre

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 10 and 11 August 2016 and was unannounced. This scheduled inspection was brought forward due to concerns raised about the service. It was carried out by an adult social care inspector and a specialist professional advisor, who was a nurse. An expert by experience was part of the inspection team for the first day. 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 for this inspection was experienced in the care of older people and dementia.

We spoke with 16 people using the service, seven relatives, nine care staff, two catering staff, the two temporary managers and the provider's group quality assurance operations manager. We also spoke with a visiting healthcare professional on the day and phoned four healthcare professionals before the inspection. We looked at seven people's care plans and associated records. We also looked at records that related to how the home was managed, such as staff rotas, staff training records, quality assurance audits and survey results. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit. We looked at notifications we had received. A notification is information about important events which the home is required to send us by law.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe.

People told us they felt safe, however we found there were days when there were not always enough staff to meet peoples care and treatment needs. Two members of staff raised concerns with us about staff shortages when other staff phoned in sick. They said, "We may have even less if someone phones in sick" and "Staffing levels could be better; with the right amount of staff there is good teamwork, but often with sickness and leave we are short, the new management do not call on agency staff. Use of agency staff worked well with the previous provider because we always had the same people coming back." We discussed this with one of the temporary managers, who confirmed they did not use agency staff, but would phone permanent staff to ask if they would come in. Over a three month period between June and the inspection, there were five occasions when the level of staff dropped below what the home had identified was needed. This equates to less than 3% of shifts during that period. Four of these were daytime shifts and one night-time shift. The temporary managers said, "During the day, management were available to assist when necessary." They described how they were not always able to cover whole shifts. The provider was in the process of recruiting new staff.

We spoke with 42 people; these were 16 people using the service, seven relatives, nine care staff, two catering staff, the two temporary managers and the provider's group quality assurance operations manager. We also spoke with a visiting healthcare professional on the day and phoned four healthcare professionals before the inspection. 38 people told us they were concerned about staffing levels in the home. People told us, "There are not always enough staff", and, "Not always enough staff, we get lots of different ones, but they are all as nice as each other" and "At times they are very busy and I have to wait for them to answer my buzzer, they all work hard and do a good job." Relatives said, "There aren't enough staff", "There just don't seem enough" and "My relative has to wait when she calls for help." Other comments included, "Staff are sometimes pushed but they still do a marvellous job and, if they can, still take [name] out for a walk in the garden" and "There are not enough staff, there is often a long wait for someone to come if I use the call button for help".

Staff told us, "With the care these residents need, full nursing care, there's not enough staff" and "I love my job, I love working here, but staffing levels make me want to leave". The temporary managers told us rotas were prepared on a weekly basis, based on people's needs and requirements. We saw staff rotas which showed the required number of staff were on duty on the days of the inspection, according to the provider's rotas. However, our observations were that staff appeared to be rushed and short of time to provide person centred care. For example, staff did not always speak with people when they completed tasks for them. This meant there were not enough staff on duty to be able to fully meet people's needs because people had to wait for staff to assist them.

The PIR stated there had been one whistle blower who was concerned about the lack of staff. We therefore brought the scheduled inspection forward.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

People were not always being protected against risks and action had not consistently been taken to prevent the potential of harm. The home was in the process of changing the format from 'old' style inherited risk assessments from the previous provider to their own, so the care files we looked at varied in complexity and completeness. We saw comprehensive risk assessments had been completed in some care files with the guidance for nurses and senior staff around how to reduce the identified risks; however, care staff could not access these. This meant not all staff would know about risks to people and see the ways of reducing those risks. Other risk assessments did not give staff guidance to keep people safe. For example, we found staff had not completed any of the essential risk assessments for one person with mobility problems who was at risk of falls. This meant the provider had not taken action to identify ways of reducing the risk of falls for this person.

People were not always kept safe from the risk of emergencies in the home. Information for staff about the arrangements in place to keep people safe in an emergency was not kept fully up to date. Personal emergency evacuation plans did not give staff the guidance they needed to be able to support the person appropriately. For example, one person's emergency plan did not say if the person was to be evacuated or taken to a safe zone in the event of an emergency. Staff we spoke with were not aware of the arrangements for each individual person. One member of staff said, "I think we'd get everyone out." The manager showed us a copy of an electronic 'traffic light' system for the rapid identification of people's mobility needs in the event of an emergency evacuation; however some staff did not have access to these. The fire risk assessment was reviewed in July 2015 and stated a new fire risk assessment was going to be produced, however this was not available. The temporary managers assured us they would obtain a copy of the updated fire risk assessment and make staff aware. Providers are required by law to complete fire risk assessments and inform staff about the details. Day staff had taken part in fire drills; however night staff had not had any fire drills. This meant, in the event of an emergency, not all staff knew what actions they needed to take to keep people safe.

People's medicines were administered by registered staff who did not have their competency assessed on an annual basis to make sure their practice was safe, in line with the provider's policy. We did not see any clinical or managerial supervision had taken place for trained staff, which meant the provider missed opportunities for improvements in the management of care, and were not kept up to date with clinical risk management. This meant the provider was not following their policy which was in place to ensure people were given their medicines safely. The temporary managers told us that trained staff received support to help them with their revalidation, however clinical supervision is part of this process. Revalidation is the new process that all nurses and midwives will need to go through in order to renew their registration with the Nursing and Midwifery Council (NMC).

Records showed several people had lost weight. One person's care plan instructed staff to monitor the person's weight closely; this was not being done. Another person's care plan said they should be weighed weekly; records showed they had been weighed monthly until July 2016 and not weighed since, although they had lost weight whilst being weighed monthly. A third person had lost 9.2 kg between January 2016 and May 2016 ; although their weight loss meant they were close to being underweight, no further weights had been recorded after May 2016, when their Body Mass Index (BMI) was 19. Because staff had recorded people's weights using kg one month and BMI another, it was not possible to see at a glance if people had gained, lost or maintained weight. It is easier to see if people are under or overweight when BMI's are used, because the measurement takes account of people's heights as well as their weights. A BMI of 18 is considered borderline underweight. We discussed this with the temporary managers during the inspection.

They assured us they would review each person immediately.

People had an assessment of their nutrition and hydration needs. However, information about people's dietary needs had not always been communicated to the catering staff. Catering in the home had been sub-contracted to a catering company; however the head cook had worked in the home for a considerable time. The head cook kept a record of people's needs, likes and dislikes, but this was incomplete. They told us nursing staff gave them information about people's dietary needs and preferences when people first moved in to the home. On the first day of the inspection, when the head cook was away, the person responsible for catering told us about people with some food allergies, such as dairy and gluten intolerances. We spoke with the head cook on the second day of the inspection. We saw one person's care file which showed they were allergic to a particular vegetable; however the head cook told us they knew nothing about this. There was no information for staff to tell them to avoid giving cranberry juice or grapefruit juice to people who were taking certain medicines, although both of these juices were available. We asked four staff if they were aware of anyone who may not be able to eat or drink certain things. Staff told us about one person with a nut allergy, but they were not aware of anyone else who needed to avoid any particular foods or drinks. This meant information about people's dietary needs and allergies was not being shared and although no-one had been harmed, people were at risk.

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

Medicines were ordered, stored, dispensed and disposed of in accordance with the provider's policy. There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. The home used a blister pack system with printed medicine administration records (MAR). We saw MAR sheets and noted that medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately stored and clear records were in place. We checked records against stocks held and found them to be correct.

We checked six MAR charts and found all to be correct. The MARs charts were audited twice a week, once by trained nurses and once by the temporary managers. We also checked bottles of medicine in the drug trolleys and found them all to have been labelled with the date they had been opened and all within the expiry date. This meant there was a system in place to check people were not given medicines that had gone out of date. This is important because out of date medicines may not be as effective.

We saw records used for the application of creams, administration of insulin and pain relieving patches. This ensured that different sites were used for injections and patches and helped to prevent people having 'sore' areas as a result of the same site being used.

We noted people who had insulin administered had regular blood tests to record blood sugar levels. When blood sugar levels had been low appropriate actions had been taken. We saw one person had been referred to a specialist diabetic nurse. This meant people were referred to healthcare professionals where necessary
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Not all staff were fully aware of the processes in place to protect people against the risk of abuse. When staff were prompted and asked about abuse, most staff were able to tell us about different kinds of abuse. All staff told us they would report to the nurse on duty or a senior, or the temporary managers, if they thought someone was being abused. Although the temporary managers were aware of who to report to, in the event

they needed to escalate their concerns, staff were not. Care staff were not aware they could report to the local authority. Staff said, "I'd talk to them myself if I found out in confidence", "I'd go to the police" and "I'd tell CQC." We saw records which showed staff had completed safeguarding training. This meant, although most staff knew how to protect people from the risk of abuse, they were not aware of how to escalate concerns to the local authority if necessary.

People told us they felt safe living at the home. People said, "Nobody abuses me, I feel safe, I would soon speak up if there was something I didn't like", "I am safe here, because everyone is kind; I have the same staff I have got to know and if I press my bell they do not take long to come", "I am safe, I have everything I need, I keep my door open day and night nobody bothers me" and "I am safe here, it is the way they look after me." Staff said, "Residents are safe here, because staff care" and "I look after people and make sure they feel safe."

Safe recruitment practices were followed before new staff were employed to work with people. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

Staff had a good understanding of their responsibilities for reporting accidents, incidents or concerns. When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective.

Staff did not have a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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. When asked about their understanding of the MCA, staff told us they weren't sure. However, staff told us people had choices even if they didn't have capacity. Staff said, "We show them and they choose what they want."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff told us they had completed training in the MCA and DoLS and records we saw confirmed this. Some care plans we saw did not contain any assessments of people's capacity to make decisions for themselves, although staff told us some people lacked capacity. Although staff had received training about the MCA, we found their knowledge varied. One member of staff said, "Nurses deal with MCA" while another member of staff was able to tell us about people being able to make their own decisions, when prompted. This meant some staff did not understand the principles of the MCA and there was a risk they may not follow them.

Where people lacked capacity to make certain decisions, the MCA code of practice had not been followed. This code explains how the MCA should work in practice. For example, people who used bedrails, who lacked capacity, should have had a mental capacity assessment completed. One person had capacity to consent to the use of bed rails, but there were no records in their care plan to show the use of bed rails had been discussed with them or they had consented. Where it was assessed that people lacked capacity to agree to their use, a best interests decision should have been made on their behalf. Other people using bed rails did not have the capacity to consent, but there were no records of best interests meetings being held where relatives and healthcare professionals had been invited to make a decision on their behalf. Staff from the home had therefore made this decision in isolation. This meant people were subject to unauthorised restrictions.

The temporary managers explained that during the transition from the previous provider to the new provider, much of the electronic records for DoLS applications were lost. During the inspection, the temporary managers found DoLS applications had been made for six people but did not know the outcomes, or whether any conditions applied. The temporary managers tried to contact the local authority for this information during the inspection. This meant, if people were subject to any DoLS or any conditions

applied to their DoLS, staff were unaware of these and people may not receive the support they needed.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

People were not supported by staff who had supervisions (one to one meeting) with their line manager. Supervision was an opportunity for staff to discuss their training needs or any concerns they had. Most staff told us they had not received supervision for five months. The temporary manager had recently started providing supervision for staff and told us they aimed to provide opportunities for staff to have at least six supervisions each year. Records showed two members of staff had received supervision.

The temporary managers told us that all staff appraisals were due to be conducted in December 2016. Appraisals were conducted on an annual basis. The providers had taken over the home in January 2016 so previous appraisal records were not available.

People's views on meals were mixed, and some people told us the quality of the meals had deteriorated in the past few months. Comments included, "Food has gone downhill since new owners have taken over, not such a high standard nor variety", "Food is never served hot enough, and now only sandwiches for tea" and "Food is 'so so', previously it was better." However, the temporary managers had undertaken a survey of people's views on the meals available, and most people indicated they were happy with the food. People told us they had never been consulted or involved in menu planning.

The tables in the dining rooms were attractively laid with the menu for the day on display. People were able to choose to eat in the dining room or in their rooms. People chose their main meal the day previously, but were able to change their mind if they wished. Alternatives were available, such as a jacket potato or omelette. We observed lunch in the downstairs dining room. Most staff were organised and attentive when supporting people. We observed one person being assisted to eat in a kindly and considerate way. However, we also saw some people did not have such a good dining experience. We saw one member of staff sitting between two people and helping them both at the same time. The member of staff got up to attend to other tasks in-between courses, which meant the people being supported had an interrupted meal. A member of staff put a clothes protector on one person without asking them. One person indicated their water jug needed to be refilled by holding it up and showing a carer. The carer took it and refilled it, but did not speak with the person when they returned the water jug. This showed the opportunity to interact with people and make the task personalised for them, was missed. People were able to use aids such as plate guards if they needed them, which meant they were able to feed themselves independently. People were asked if they would like a drink, and offered a choice between blackcurrant or lemon squash. Staff told us, "We're told when people have nutritional needs". One person told us staff knew they liked mustard with all their meals and this had become a joke which they enjoyed with the person.

When observing tea and coffee being served, staff appeared to know how each person liked theirs, and served it without asking. Staff said, "I know when people like tea or coffee, but I'll offer alternatives. We asked staff giving morning drinks how they knew about people's needs, such as people with diabetes or swallowing difficulties. New staff learn by "shadowing existing staff" and "I'll go to the nurse if one of the residents' with diabetes asks for a drink with sugar in it."

Throughout the home, the décor was tired and in need of refreshing. There were areas in the ceilings where water damage had left marks. Staff said, "We've had problems with leaks for years." The temporary managers told us, and the group quality assurance operations manager confirmed, the provider was committed to updating and refurbishing the facilities. We saw extensive plans were in place to renovate the

building and facilities. Staff said, "We know there are very, very good plans and they're doing the roof and showers now" and "There are big plans for improvement, I look forward to the new Dementia Unit opening."

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: "They have had good training" and "They know me well and what I like". Relatives told us, ""[Name] has come on in leaps and bounds. She was very poorly but has started walking round a little bit". Staff told us they had the training they needed when they started working at the home, and were supported to refresh their training. Staff told us, "There are a few things we need more training in, such as looking after people with a colostomy".

We viewed the training records for staff which confirmed staff received training on a range of subjects. However, staff said, "We did a lot of training in one day" and "I did two or three courses on the one day, it was a lot to take in." Training completed by staff included moving and assisting people safely, fluids and nutrition and dementia awareness. This meant people were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. New staff were supported to complete an induction programme before working on their own. They told us, "Induction was good, I learned a lot". Induction was based around the Care Certificate, which is a recognised standard to give staff the basic skills to look after people.

People told us they were asked for their consent before staff assisted them with day to day tasks. Although most people kept their bedroom doors open, we saw staff knocked on their doors and waited for a response before entering people's rooms. We heard staff asking people what they would like and waiting for a response before proceeding. This was confirmed by residents, who said staff asked them, for example, what they would like to wear and would hold up two outfits for them to choose from.

Good

Is the service caring?

Our findings

The service was caring.

People said they were supported by kind and caring staff. Staff were seen to interact with people in a kind and compassionate manner, and used appropriate volume and tone of voice; terms of endearment were used appropriately and this was received positively. We saw two occasions when one member of staff engaged someone in good humoured banter; the people they were talking with at the time were laughing and very much enjoyed the interaction. There were other occasions when we saw friendly banter between staff and people. People told us, "We always have a laugh, they know my little ways." Relatives told us, "The carers are run ragged, but they still have a friendly chat" and "It's so nice having a banter." A visiting professional told us that "I see carers working considerately, they do their best".

People received care and support from staff who had got to know them well. It was very apparent staff knew the people they cared for well, such as their life histories, likes and preferences. For example, a member of staff told us one resident liked to have their laundry returned to them by midday, so staff knew one of their first tasks each morning was to collect this person's laundry to make sure this happened. Staff said, "It is important to get to know people, I do this by taking an interest in their personal history and asking questions about their family while I am giving care. They like it when you remember birthdays and special events."

People were treated with kindness and compassion in their day-to-day care. People told us, "I am well looked after, staff are kind and gentle." Relatives told us, "Some staff are better than others, all the seniors are good, some of the new young ones not so good" and "The care is good, fantastic caring staff."

People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. Relatives told us they were always made welcome and said, "They've always told us to make ourselves a cup of tea." A relative told us they were passing by at 9.30pm and just popped in, they went to their loved one's room and said they "saw them snuggled up asleep in their bed"; they told us they found this very reassuring.

The relationships between staff and people receiving support demonstrated dignity and respect at all times. When people were hoisted in communal areas, staff ensured people's dignity and privacy was protected by using screens and shutting curtains. When we asked a resident to give us an example of how staff treated them with dignity and ensured their privacy they told us, "They come in first thing in the morning and first thing they do is pull the curtains so no one can look in and see me getting dressed". We observed staff moving people using a hoist; staff spoke with people throughout and explained what they were doing. Each person used slings that were personal to them; this ensured they fit the person properly and meant there was no risk of spreading infections.

People told us, "I now need everything done for me and I am very comfortable about it", "Care here is 100% good, I feel very comfortable with staff and they are all nice to me" and "Staff are kind and polite, I am very

happy with personal care, I prefer ladies but I have a gentleman sometimes." None of the people we spoke with could remember if they had been asked for their preferences around the gender of their carer, only one person spoken to told us they did not want a carer of the opposite gender. We discussed this with the manager, who told us they were aware of this situation and were endeavouring to make changes to the staff rotas so people's choices were respected.

People told us they were happy with the care they received and staff gave them choices. People told us they were free to decide when they get up or go to bed, and could please themselves what they did during the day. Staff helped people with their medicines; no one self-medicated. We saw in some care plans people had been asked if they wanted to continue to self-medicate after moving in to the home, but had not chosen to. This meant people were given choice and their wishes respected. People said, "Some of them have little experience, but the others know me well and know what I like, they help me to do whatever I want". Relatives told us, "Staff are very pleasant, my friend seems happy", "Staff are ever so friendly" and "Staff are fantastic, nothing is too much trouble." Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way.

The temporary managers were in the process of introducing surveys, to obtain people's views. A questionnaire to obtain people's views about the food had recently been completed, however the results had not been analysed. Other questionnaires to seek the views of relatives and visiting healthcare professionals were also being introduced. This meant a wide range of people involved with the home would have their views considered.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive.

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Where local authorities had provided detailed assessments and care plans prior to people moving in to the home, we found not all of the information from these assessments had informed the home's plan of care.

Some care plans had been re-done using the new providers' documents; others still had paperwork from the previous provider. As a result, the care plans that we looked at were inconsistent and variable in quality. Some care plans contained detailed, person-centred information which included people's decisions regarding end of life care and social histories. Other care plans did not include information that enabled the staff to monitor the well-being of the person. We saw four care plans where there were insufficient records of treatment provided to wounds or records detailing the condition of wounds throughout the healing process. For example, one person with a pressure ulcer in May 2016 was noted as having all skin areas intact in June 2016, however there were no records of what treatment the person had received and no description of the wound during this time to confirm healing. Another person's care plan did not give staff guidance should the person developed either a high blood sugar reading or a low blood sugar reading. This meant there was a risk that staff might not be able to identify if the person was showing signs of high or low blood sugar readings, and the person might not receive treatment in a timely way.

All care staff we spoke with told us they did not have access to the care plans and said, "We only know what the nurses tell us", "Sometimes we find out information which has not been handed over" and "Only the nurses and seniors see the care plans, we don't touch them." Other comments included, "We don't read care plans, we learn by observing others, and passed-on information", "We've got small folders in people's rooms, with daily notes, position charts, hourly checks". Information in some care plans was muddled and most did not contain any information about the person's likes, dislikes and people important to them. We raised this with the temporary managers, who told us staff would be given full access once the care plans had been updated.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We saw one person's care plan which said they used specific non-verbal signals and body language to communicate. Although the care plan instructed staff to 'read body language to understand their needs', there was no description of the signals the person used, or what they meant. An assessment of the person's mobility needs said it was difficult to assess if the person experienced any pain when moving. This meant staff may not have been aware of the non-verbal signals and body language the person used when trying to communicate they were in pain. Another person's care plan stated, "Requires regular pain assessment, uses numerical pain rating form." Although there are several tools available to help staff assess pain levels for people who can't communicate, none of these were being used. This meant staff did not have

appropriate guidance to be able to meet people's needs, and there was a risk people may not be receiving pain relief when they needed it.

People or their relatives were not involved in developing their care, support and treatment plans. None of the people we spoke with were aware of their care plan. Relatives told us they had not been involved in a formal review, but said they were aware of all aspects of their loved one's care. The temporary managers told us they were in the process of inviting people in to review people's care plans. One care plan stated monthly reviews should be completed; however these regular reviews had not taken place. Another care plan we looked at lacked risk assessments, personal history and regular reviews, despite a form noting these should be done monthly. Known pressure ulcers had not been recorded and there was no regular update to the pressure ulcer monitoring tool. Daily written notes had not been completed since June 2016. This meant information in care plans lacked up to date detail which staff needed to be able to meet people's needs.

Staff had access to information which was kept in people's rooms, such as records of position changes and application of creams. One person's records stated they should be repositioned every four hours. In the two days prior to the inspection, records showed this person was not moved for five hours one day, and five hours 20 minutes the day previously. Instructions for staff on how to apply cream to the person stated, "Apply to affected areas as directed"; however there were no directions available. We saw one cream had been applied twice only. Another cream had been applied twice on three days, once on 23 days and not at all on nine days. This meant staff did not have any instructions to follow and the person therefore had an increased risk of developing pressure ulcers because staff may not have provided the appropriate care and treatment.

Health and social care professionals were not always involved where necessary. One person's care plan stated they needed to be referred to a speech and language therapist to be assessed for swallowing difficulties; this had not been done.

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

People sometimes received support from healthcare professionals. An example of this was visits from the district nurse to visit people who needed regular blood tests. Staff told us healthcare professionals such as a dietician and a GP regularly visited the home. We saw records in some care files that visits from healthcare professionals had occurred and recommendations they had made had been implemented. Trained staff we spoke with were knowledgeable about the health needs of people including managing complex medical conditions that required constant monitoring.

We saw people received care in accordance with identified wishes in their care plans, such as no bright lights for someone who disliked bright light and hourly visits for one person who was unable to use the call bell.

People who took a medicine to prevent blood clots needed to have regular blood tests to check how long it took for their blood to clot. The home had recently purchased a machine that offered a far less invasive way of doing blood tests. This meant temporary managers sought ways to improve people's experience of care in the home.

People had access to activities they could be involved in, however activities were not provided as the timetable stated. Staff told us, "I find it upsetting that people only get one to one time when they are having care" and "I feel there is not enough for people to do or to stimulate them. I hope when the new activity co-

ordinator starts this will be better." To improve activities available, the manager had recently appointed a new activity co-ordinator who would be working full time, and was in the process of recruiting a second activities leader. This will mean that activities will be provided seven days a week. There were no activities taking place on the day of the inspection as the newly appointed activities co-ordinator was having their induction. We saw several bookcases with a variety of books available. We saw a Monday to Friday timetable which provided activities such as film club, keep fit to music, board games, crafts, bingo, gardening, painting, and music, however these were not provided as stated. One relative told us how much their relative had enjoyed the activities and had joined in with everything. We also saw that family members and friends were invited to suggest activities that their family members had enjoyed in the past. When we asked people if there was enough to keep them occupied they told us, "If you choose to there are things to do" and "I'm quite happy to sit and be quiet and listen to the radio". Relatives told us, "[Name] has a choice of doing things but chooses not to interact with others." We were told that, weather permitting; staff took people for a walk in the secure gardens around the home.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. Everyone we spoke with said they would feel comfortable in raising a concern if they needed to. There had been six complaints in the previous five months and these had been investigated thoroughly and people and their relatives were satisfied with their responses. One person told us, "Staff are definitely kind, they are all nice, I could talk to any of them if I was worried or needed something". Relatives told us, "I have no concerns in the slightest, our relative seems so happy and has made progress" and "No concerns whatsoever; anything at all they ring me." Two relatives also told us their loved ones never had any complaints when they asked them. The home had a complaints policy and also had a 'comments' book kept in the main hall where residents, staff and family members were invited to identify any concerns and ideas for improvements.

We observed a number of compliments which included the following; "Thank you so much for your care and compassion", "We did enjoy the cowboy afternoon, thank you all so much for all your hard work". Family members made positive comments regarding the new temporary managers including how they listened, how they hoped they would stay for a long time and how approachable they were.

The temporary managers sought people's feedback and took action to address issues raised. Relatives said, "If I raise anything, it's done." One person told us there had been a residents' meeting recently but they had forgotten to attend. The temporary managers confirmed they had arranged a family meeting, but no-one turned up. The temporary managers were therefore arranging to speak with relatives individually.

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well-led.

Some quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The group quality assurance operations manager completed quality audits every six months and had identified where environmental improvements needed to be made; this work was on-going. We saw the audit which was completed in May 2016 which identified that night staff needed to complete a fire drill; this had not been completed at the time of the inspection. The provider confirmed the fire drills had been completed after the inspection. Other audits had not identified the issues and causes for concern we found throughout the inspection. In particular they had not identified the issues we found around staffing levels, staff understanding their responsibilities about how to escalate safeguarding concerns and keeping people safe in emergencies. They had not identified where risk assessments were not in place, where staff competency assessments were required for medication or where the principles of the MCA were not being met. The provider had not ensured staff were supervised or had access to care plans and care plans did not contain complete, up to date and accurate information about people's conditions. The provider had not identified that some people did not enjoy a good mealtime experience, and people were not always referred to healthcare professionals in a timely way.

Care plans were in the process of being re-written using the providers' new format. The manager told us nurses and senior carers should audit the care plans monthly, however there were no records of these being done. This meant internal audits had not identified shortfalls and action had not been taken to improve the care plans. Staff told us, "I'm not aware of any audits." This meant some quality assurance systems were ineffective at making sure any areas for improvement were identified and addressed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

When areas for improvement were identified, the temporary managers were involved in writing the action plans. The group quality assurance operations manager checked any actions had been completed during their next visit. The group quality assurance operations manager said they would send us the updated action plan from the May 2016 audit by 16 August; this showed that nine of the 14 actions due had been completed.

Everyone we spoke with told us the new temporary managers were approachable and were making a difference. Relatives said, "The home runs very smoothly" and "It's definitely getting better." Staff said, "They're lovely. They stepped in and have taken on a lot", "We can walk in and they're brilliant, they're approachable" and "They've really worked hard."

Many people living at the home were aware of the new temporary managers and knew them by name. We saw a conversation between one person and one of the temporary managers; there was a lot of laughing and teasing on the part of the person, it was apparent that they felt comfortable with the temporary

manager. The temporary manager was able to reassure the person about their personal situation. One relative said, "I asked them how long they'd be here and they said, "Till we find the right person for the job". I think they're the right people, it's so different now." Visitors told us, "I have found the managers to be friendly and helpful, they always seem to be around" and "I see the new managers about, they will always have a chat."

The service promoted a positive culture. Staff told us, "They are absolutely fabulous; I wish they could stay" and "They've arranged so many different things." The temporary managers had identified the values they wished the home to have; these included having "Well cared for and happy residents" and "Reward staff for hard work." However, although staff we spoke with were not aware of the values, our observations were that they were working in line with them.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. The temporary managers had distributed questionnaires and analysed the results which showed 73% of staff were satisfied and 27% were unhappy overall. Staff had been asked questions about the support and training they received and how they felt staff morale was. However, the analysis did not differentiate between the different sections of the questionnaires, so did not provide information about specific topics, only an overall score. This meant the provider was not able to clearly identify which questions received low scores and were therefore not able to identify areas where they needed to take action. Staff commented that the support they received and the training they were given was good. People had completed a survey about meals but this information had not been analysed at the time of the inspection.

The temporary managers had made links with the local community. Various activities had taken place where members of the public could visit the home, such as a Macmillan coffee morning and a table top sale. The temporary managers had arranged for the mayor to attend for one person's 100th birthday celebration. The temporary manager said, "I'm trying to do something community based every month, so there will be something for all of our residents to enjoy monthly." People had been supported to attend several social events such as a strawberries and cream tea, teddy bears picnic and barbeque. The temporary manager told us, "We're trying to get people out wherever they can."

People and staff had confidence the temporary managers would listen to their concerns and would be received openly and dealt with appropriately. Relatives told us, "There's been an improvement since they've taken over". Staff said, "The new managers are only temporary but they have had meetings with staff and have listened, and appear to be understanding and approachable."

All accidents and incidents which occurred in the home were recorded and analysed to see if there were any trends or patterns. Accidents and incidents were reviewed by senior managers to ensure appropriate actions had been taken. The temporary managers had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

Various staff meetings had been arranged to ensure everyone was involved in the decisions made and to ensure information was shared. At a general staff meeting in July 2016, staff had been informed that documentation was not being completed to the required standard. Meetings were also held for senior carers and night staff, where again staff were reminded of the need to complete the paperwork properly.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment in accordance with this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and operated effectively to ensure compliance with the requirements in this Part.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by sufficient

Treatment of disease, disorder or injury

numbers of suitably qualified, competent, skilled and experienced persons.