The Royal British Legion

Mais House

Inspection report

18 Hastings Road
Bexhill on sea
TN40 2HH
Tel: 01424 215871
Website: maishouse@britishlegion.org.uk

Date of inspection visit: 28 and 30 October and 02 November 2015
Date of publication: 29/01/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We undertook an unannounced inspection of this service on the 28 and 30 October and 02 November 2015.

Mais House provides accommodation, personal and nursing care for up to 54 older people living with a range of physical health problems, such as Parkinson's disease, diabetes, strokes and cancer. There were also people who were now living with early stages of dementia and those who were receiving end of life care. There were 51 people living at the home at the time of our inspection. Accommodation is arranged over two floors and each person had their own bedroom. The home is divided into two units nursing and residential with communal areas shared by both units. Access to the each floor is gained by a lift, making all areas of the home accessible to people.

This service did not have a registered manager in post. The registered manager resigned at the end of 2014. A registered manager is a person who is 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.

Summary of findings

During this inspection we met the manager who had been in post for ten months and had submitted their application to the CQC to become the registered manager.

We last inspected the home 30 April 2014 and no concerns were identified.

People and visitors spoke positively of the home and commented they felt safe. Our own observations and the records we looked at did not always reflect the positive comments some people had made.

People's safety was being compromised in a number of areas.

Care plans did not all reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as end of life care did not have sufficient guidance in place for staff to deliver safe care. Not everyone had risk assessments that guided staff to promote people's comfort, nutrition, skin integrity and the prevention of pressure damage. Equipment used to prevent pressure damage was not set correctly. This had resulted in potential risks to their safety and well-being. Staffing deployment had impacted on people receiving the support required to ensure their nutritional needs were met.

People were not protected against the risks of unsafe medicines management. The staff were not following current and relevant medicines guidance. We found issues with how medicines were managed and recorded.

Risks associated with the cleanliness of the environment and equipment had been not been identified and managed effectively. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff, however the evacuation plans did not reflect the decrease in staff in the afternoon and night.

Staffing levels were not sufficient and staff were under pressure to deliver care in a timely fashion. The delegation of staff placed people at risk from accidents and incidents due to lack of supervision in communal areas.

The delivery of care suited staff routine rather than individual choice. Care plans contained information on people's likes, dislikes, what time they wanted to get up in the morning or go to bed. However these were not always followed. We saw staff make decisions about where people spent their day without consulting the individual. For example, remaining in a communal area whilst requesting to go to their room. The lack of meaningful activities for people in their rooms impacted negatively on people's well-being.

Whilst people were mostly complimentary about the food at Mais House, the dining experience was not an enjoyable experience for people who remained in their room. People were not always supported to eat and drink in a safe and dignified manner. The meal delivery was not efficient and we were told by people who were assisted in their room that they didn't often get a hot meal at lunchtime. We also observed food left in front of people without being offered the support they needed to eat. We also could not be assured that people had sufficient amount of fluids to drink.

Quality assurance systems were in place. However the quality assurance systems had not identified the shortfalls we found in the care delivery and documentation.

There were arrangements for the supervision and appraisal of staff. Although staff supervision took place to discuss specific concerns, regular supervision and appraisals had not ensured good practice was embedded into care delivery.

Mental capacity assessments did not always meet with the principles of the Mental Capacity Act 2005, as they are required to do so. We saw that not all peoples' documentation reflected people's mental capacity correctly and that "do not attempt cardiopulmonary resuscitation" were not accurate. Care plan records did not always reflect that people were involved or had agreed to decisions and changes made about the care and treatment they received.

People we spoke with were complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Some staff interactions demonstrated they had built a rapport with people and people responded to staff with smiles. However we also saw that many people were supported with little verbal interaction and many people spent time isolated in their room. We saw some interactions from staff that were not respectful to the person they were supporting.

Summary of findings

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Mais house all had registration with the nursing midwifery council (NMC) which was up to date.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

Summary of findings

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

Mais house was not safe. Risk assessments were devised and reviewed monthly. However, management of people's individual safety and skin integrity was poor and placed people at risk.

There were not enough staff to meet people's needs. People's individual needs were not met due to staff delegation and numbers.

Poor recording and unsafe administration of medicines placed people at risk of not receiving their prescribed medicines. However, medicines were stored safely.

People told us they were happy living in the home and they felt safe. Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe.

Is the service effective?

Requires improvement

Mais house was not consistently effective. Mental capacity assessments did not meet with the principles of the Mental Capacity Act 2005.

Meal times were observed to be solitary and inefficient for people in their rooms with food being served to people who were in an inappropriate position or left with their meal untouched in front of them. Senior staff had no oversight of what people ate and drank. No guidance was available on how much people should be eating and drinking to remain healthy.

People received a wide variety of homemade meals, fresh fruit and vegetables. Home baked cakes and desserts were also particular favourites. People were provided with menu choices and the cook catered for people's dietary needs.

Staff received on-going professional development through regular supervisions, and training.

Is the service caring?

Requires improvement

Mais house was not consistently caring. People and some visitors were positive about the care received, but this was not supported by some of our observations.

Care mainly focused on getting the job done and did not take account of people's individual preferences or respect their dignity. People who remained in their bedroom received very little attention.

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks and care without any interaction with the individual. However we also saw that some staff were very kind and thoughtful and when possible gave reassurance to the people they supported.

Summary of findings

Is the service responsive?

Requires improvement 

Mais house was not consistently responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

People told us that they were able to make everyday choices, but we did not see this happening during our visit. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home felt isolated.

A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be resolved and investigated.

Is the service well-led?

Inadequate 

Mais House was not well led. There was no registered manager in post.

Checks and audits had not identified shortfalls found during this inspection or enabled the provider to meet regulatory requirements.

The home had a vision and values statement but we did not see the values acted on during the inspection.

People spoke positively of the care, however, commented that staffing levels and deployment of staff could impact on the running of the home.

The management of the home were reactive to situations rather than ensuring the service was proactive in establishing good care.

Mais House

Detailed findings

Background to this inspection

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

The inspection took place on the 28 and 30 October and 2 November 2015. This visit was unannounced, which meant the provider and staff did not know we were coming.

Two inspectors undertook this inspection.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we spoke with the Local Authority and Clinical Commissioning Group (CCG) to ask them about their experiences of the service provided to people.

We observed care in the communal areas and over the two floors of the home. We spoke with people and staff, and observed how people were supported during their lunch. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the afternoon in the main communal area. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spent time looking at records, including eight people's care records, five staff files and other records relating to the management of the home, such as complaints and accident / incident recording and audit documentation.

We spoke with 14 people living at the service, three relatives, eight care staff, the activity co-ordinator, two housekeeping staff, two registered nurses, the area manager and the manager.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Mais House. One person told us, "I have no concerns." One relative confirmed they felt confident in leaving their loved one in the care of Mais House. Another relative told us, "I think It's a good home, I keep a close eye on things because I have to." We found however there were shortfalls which compromised people's safety and placed people at risk from unsafe care.

Peoples' risk assessments did not always reflect their actual needs and some lacked sufficient information and guidance to keep people safe. Care plans contained risk assessments specific to health needs such as mental capacity, mobility, continence care, falls, nutrition, pressure damage and a person's overall dependency. They looked at the identified risk and included a plan of action to promote safe care. However we found that not everyone's health, safety and wellbeing was assessed and protected.

Risk associated with use of pressure relieving equipment and the use of bedrails had not always been assessed and used appropriately. For example, three pressure relieving mattresses were found to be set on the wrong setting on both days. One mattress was set on 70 kgs when the persons' weight was 38kgs. This person was on continuous bed rest. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. We also found bed rails being used with pressure relieving mattresses. The risks associated with their use had not been assessed and did not comply with safety guidelines as the space between the mattress and the top of the bed rails were less than that recommended by the health and safety executive. People were therefore at risk from falling. These were discussed immediately with the manager who told us that they would ask the maintenance team to immediately check the identified beds.

Risk assessments did not include sufficient guidance for care staff to provide safe care and care plans were not being followed. For example, good skin care involves good management of incontinence and regular change of position. There was guidance for people who stayed in bed to receive two or four hourly position changes and the use of a pressure mattress. However for people sitting in chairs or wheelchairs in communal areas there was no change of position or toilet breaks in their care planning for staff to follow. During the inspection three people had not been assisted to access the toilet or offered a change of position for up to five hours whilst sitting in a communal area. One person we visited had sat in their room in the same position for approximately five hours including the lunchtime period.

We found that five people in wheelchairs were sat with their feet on the foot rests which meant they could not change their position in the chair themselves. This placed these people at risk from pressure damage from being in the same position for up to four areas.. We acknowledge that for one specific person who self-propelled their wheelchair that this was their choice.

We observed a person being lifted and moved by an electrical hoist. An electrical hoist moves people who are unable to move themselves. The manoeuvre took over 40 minutes and was not safe. The sling did not fit the person and this was only discovered once the hoist was in motion. It was uncomfortable for the person and did not support them properly. Another sling was found and the move with the hoist restarted. The persons' hands were caught and trapped under the metal bar and then the hoist didn't work properly so the move was abandoned until another hoist was found. The whole procedure was uncomfortable for the person and placed them at risk from injury.

Accidents and incidents had been documented with the immediate actions taken. However there was a lack of follow up or actions taken as a result of accidents and incidents. For people who had fallen which were unwitnessed by staff, there was no record of an investigation or a plan to prevent further falls. This meant that the provider had not put preventative measures in place to prevent a re-occurrence and protect the person from harm. The provider was unable to show there was any learning from accidents and incidents.

We saw a one person had a number of bruises that were not reflected in their care documentation. We could not find any completed accident forms for this type of injury. We asked the registered nurse where we could locate the details of the incident. Staff could not find this during our inspection and could not tell us how the bruises had occurred.

Personal emergency evacuation plans (PEEPs) were in place. The PEEPs lacked guidance for safe evacuation. There was no further information to guide staff in the safe

Is the service safe?

evacuation of each person. Staffing levels decrease in the afternoon and night time and this was not reflected in the evacuation list. Staffing levels especially at night would not be able to respond to the actions detailed in the Peeps, due to the layout of the home and four members of staff. This placed people at risk from failed emergency evacuations.

Whilst infection control measures were in place, not all areas were clean and hygienic. We saw that two of the bathroom hoists were not clean under the seats. In one of the accessible toilets on the ground floor we found that there was no bin bag in the pedal bin. A disposal bag of soiled wipes had been left on the base of the pedal bin. There was also a full urine bottle in the hand wash basin in this toilet. Chairs in bedrooms and communal areas were not all clean. In one room there were visible stains on the chair along with an offensive smell. In the first floor sluice area there were dirty commode inserts and a yellow bag for medical waste was on the floor The sharps bin in one treatment room was not dated on opening and was full. We saw barrier creams and ointments in two peoples' rooms and it was difficult to read the labels on some of these. Some cream pots when handled were greasy on the outside indicating poor hygiene practices.

The service had electrical hoists to move people and people had been allocated their own sling. However the use of slings during our inspection in communal areas was not always individual and the same slings were used for different people without being cleaned. The use of shared slings placed people at risk from cross infection.

We looked at the management of medicines and found shortfalls in records and medicine administration that had the potential to impact on the safety and health of people. The medicines administration records (MAR) charts we looked at on the residential wing were complete; however MAR charts on the nursing wing had gaps where staff should have signed on administering medicines. These had not been identified by staff or checked by staff to ensure that medicines had been given as prescribed to meet their health needs.

Whilst there was an organisational policy for the use of "as required medicines" we found it had not been followed. There were no individual person specific protocols for giving people medicines that were prescribed for use "as and when required". As required medicine is prescribed for people that may require it occasionally, such as laxatives indigestion medicine and pain relief. Guidance for staff to manage as required medication was not included in individual care plans. For people who required pain relief there was a lack of pain charts which enabled staff to identify and monitor effectiveness of pain relief. This was specifically noticeable on people who were receiving end of life care. Just in case medicines are prescribed for people who are nearing the end of their life by their GP to ensure symptoms can be managed effectively and without delay. The prescribed medicines included medicines for pain relief.

One person who was receiving end of life care was prescribed for 'just in case medicine' but there was no information to reflect when this was to be administered or guidance for staff as to when this might be required.

We reviewed the file of one person who was diabetic. Staff measured and recorded the person's blood sugar level twice daily and administered insulin. However, there were no guidelines for staff as to what the person's blood sugar measurements should be and what levels should trigger the administration of the person's insulin. Staff could not tell us what this person's normal blood sugar was or what range the blood sugar should be to remain healthy. The person's MAR chart stated that insulin was prescribed to be administered in the morning. However, staff gave the person insulin in the evening. Staff told us that this had been agreed by the person's GP but that the MAR chart had not been updated. This was not documented with the persons care plans or medical history.

We also found that one person had been prescribed a liquid antibiotic and we found two partially used bottles in the fridge that had been opened and were past the expiry date. This person had not completed the course and no record had been kept of why the prescribed course had not been completed. The staff we spoke with were not clear of the reasons why this medicine had not been administered.

The above issues demonstrate that care and treatment was not always provided in a safe way for people. These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. Mais House is divided into two units, residential and nursing. The staff teams for the two units work separately. There

was no dependency tool in use to align staffing levels to peoples' specific needs. We were told that the staffing levels were fixed at a ratio of one staff member to five people.

On the residential unit in the morning there was one senior and two care staff for 18 people, this reduced to one senior and one care staff member in the afternoon. On the nursing unit there were 33 people being cared for by five care staff and two nurses in the morning and reduced to two nurses and four care staff in the afternoon. At night there were three care staff and one nurse to look after 51 people. There had been a number of registered nurses leaving and on annual leave and this meant a high number of agency staff were being used. On one day during our inspection process we saw that three agency nurses were working.

Most people on the nursing unit required two staff to assist them with all personal hygiene needs, assistance with mobilising, and one staff member to assist or prompt them with their nutritional needs. The staffing levels were not flexible to meet people's changing needs for example, when someone became unwell and required extra support staff told us "It's hard to spend time with our residents in a way that we want, we rush from room to room to get things done."

We saw that staff were busy throughout the day and that care was not delivered in a timely manner. Personal care to get people up for the day was still being undertaken at midday and this was not always people's individual preference. This meant that people had not had an opportunity to enjoy their morning as they were waiting for staff. On the nursing unit staff told us the people who lived there were mainly high dependency. They told us people needed hoisting for all care delivery, and some needed two members of staff for all movements with supporting moving aids such as sliding sheets. We saw staff deliver task orientated care as they were continuously rushing from one task to another. Staff did not have time to ask people where they wanted to spend their day, or if they wanted a bath or wanted to go to activities and therefore the care delivered was to suit staff and staffing levels. One person arrived downstairs upset that they had not been able to have their shower as staff had not had time.

Staff struggled to provide care and to supervise people in communal areas. We observed that the main communal area was left unsupervised for periods of over thirty minutes (11.40 am -12.10 pm) and in the afternoon (3.30 pm) for over 40 minutes without access to call bells leaving people at risk from falls. Relatives told us that weekends were short staffed and staff were always busy. Another relative told us that "There have not been enough staff recently and a lot of agency staff are here." Another relative told us that staff shortages occurred at weekends and that staff were always busy. One relative said, "We have been here and not seen any staff." Staffing levels were not sufficient or consistent to meet people's needs. One person said "It depends how many people they have to see to so they cannot come to me quickly." We observed one person waiting for staff for over 20 minutes to go to the bathroom, we asked for assistance for them from the manager as we were unable to find a staff member to assist this person.

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

Staff received training on safeguarding adults and understood clearly their individual responsibilities. Staff and records confirmed that staff received regular training and recent safeguarding activity in the home had led to greater staff awareness. Staff had recently had a group supervision session on safeguarding people. Staff were able to give us examples of poor or potentially abusive care they may come across working with people at risk. They talked about the steps they would take to respond to allegations or suspicions of abuse. Staff were confident any abuse or poor care practice would be quickly identified and addressed immediately by the senior staff in the home. They knew where the home's policies and procedures were and the contact number for the local authority to report abuse or to gain any advice. One person was at risk from people outside of the home. Guidelines were in place for staff to follow in order to protect this person.

People were protected, as far as possible, by a safe recruitment practice. Records included application forms, identification, references and a full employment history. Each member of staff had a disclosure and barring checks (DBS) these checks identify if prospective staff had a criminal record or were barred from working with children or adults, completed by the provider. Interviews were undertaken and two staff completed these using an interview proforma. There were systems in place to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse.

Requires improvement

Is the service effective?

Our findings

People and visitors spoke positively about the home and the care and support provided by the team of staff. Comments included, "Staff are good, I trust that they look after us," and "Staff are very good and provide good care." One visitor said "They (the staff) manage very well, but sometimes I think it's sometimes disorganised and staff don't always know what's happening." Another visitor said, "I think there needs to be better communication, staff changes make me feel uneasy."

We found that staff at Mais House did not consistently provide care that was effective.

Whilst people told us the food was 'okay', 'good and tasty', we observed that the lunchtime experience on the first day of the inspection process was varied. Meal times were not a pleasurable experience for everyone or made to feel like an enjoyable event.

The main dining area was on the ground floor. The dining room was attractively set up and there people chose where they sat and who they sat with. People seated at the dining tables received their meal immediately and enjoyed a meal served at the right temperature. They received very good attention from the kitchen staff. However, for people in their rooms we saw that staff took meals to people covered but not everyone received timely assistance. We saw that six people in their bedrooms were not assisted straight away until all the other people had been served. Two people waited for 20 minutes for staff to assist them whilst their food was in front of them. On the first day of the inspection the hot pudding was also served at the same time to people in their rooms. This meant that for some people the meal had cooled considerably and people did not eat very much. Staff told us it was to save time. Following discussion with the chef who stated that this was not what should be happening this did not occur on the second day of inspection. We observed that the hot pudding was kept in a hot trolley until people had finished eating their main meal.

What support was given was given intermittently by different staff to people in their rooms. We observed two examples where staff were standing and leaning over bedrails without gaining eye contact or talking with the person they were assisting. The level of support to enable people to eat well was poor. We saw staff prompt a person to eat but was not consistent or done in a way that encouraged the person to eat. The staff member popped in the room, placed the fork in the persons hand saying eat up and left the room. The staff member did not return to check and the person did not eat their meal. The meal service was seen as a task to undertake rather than a social and enjoyable experience.

We looked at eight of the fluid charts. The charts showed low fluid intakes for five people, for example, one person fluid intake was less than 400 mls in 24 hours. The recommended fluid intake for this person based on their weight for 24 hours was 1200 mls.

Records for food intake were not kept for everyone that required them and were generic, for example, 'some main and a little pud. This meant that there was no clear oversight of how much people had eaten. One care staff member told the nurse that a certain person had eaten none of the lunch offered. An alternative was not offered. This person's records did not reflect that the person had not eaten when we checked later on in the day. This person was losing weight. We looked at nutritional records and found that the nutritional tool was not used in full and therefore was not effective in monitoring people's nutritional needs.

Records on food and fluid intake must be legible, accurate, and specific and should the desired amount of intake not be achieved then this should prompt staff to encourage drinks and food. Eight fluid charts showed no entries after 5:00pm. Fluid charts were not added up at the end of the 24 hour period and therefore were not being used in a way that provided effective monitoring to prevent dehydration. One person had had a urinary tract infection, yet there was no prompt to staff to tell them to encourage fluids and what the minimum intake should be in 24 hours. There was no other record of staff monitoring the colour or odour of urinary output where required that would indicate whether the person was taking enough fluids. For example strong odour and dark colour indicates that not enough fluids are being taken. We found two further examples of people who experienced recurrent urinary infections.

These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

People told us that staff working in the home were trained and looked after them well. One visitor said, "The training covers everything I think, they certainly seem competent."

All staff told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. Staff received an induction programme which lasted a month and ongoing training support. Newly appointed staff shadowed other experienced members of staff until they and the service felt they were competent in their role. This was confirmed by a member of staff who said, "I was fully supported through the induction process, I am still supported by senior staff I always have someone I can ask for advice, all staff are helpful."

Staff and training records confirmed that a programme of training had been established and staff had undertaken essential training throughout the year. This training included health and safety, infection control, food hygiene, safe moving and handling, safeguarding and dementia care. Additionally, they said there were opportunities for staff to complete further accredited training such as the Diploma in Health and Social Care. However some staff members told us that training was needed to help them feel safe and to respond to people with behaviours that challenge. We saw that despite training being provided in moving and handling, nutrition and dignity, competency in this area was not embedded into practice.

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

All staff told us that they felt supported by their peers and felt they could speak to senior staff in the home and that they would be listened to. Staff confirmed that in the past support had not been good. They had not received regular supervision and there had been confusion on what roles and responsibilities staff had been allocated. Staff were now receiving individual supervision. Systems for regular supervision and annual staff appraisal had been developed though not embedded in to practice as yet.

Staff had undertaken training on the MCA and Deprivation of Liberty Safeguards (DoLS). Care staff had a basic understanding of mental capacity and informed us how they gained consent from people. Records supported people's consent was gained in a consistent way throughout the home. Most consent forms were well completed and demonstrated that people had been consulted about their care and treatment. However, other records were incomplete and there was no evidence how staff had gained consent. For example, people's capacity was not assessed routinely following admission, and there was no evidence how decisions were made for three people who lacked capacity to make an informed choice. For example, when bed rails were being used the rationale and discussion to ensure safe and effective use was not clearly documented. One person had bedrails in place but no documentation as to why this person who was mobile had bedrails in place.

On one person's file we saw that a "Do not attempt cardiopulmonary resuscitation" (DNACPR) form had been completed. The form stated that the person did not have the capacity to make a decision about whether they wished to be resuscitated. However, there was no evidence that a mental capacity assessment had been carried out. At a later date the person had participated in a care and service review and had stated that they did not wish to be resuscitated, signing a review form to that effect. We found two further DNACPR that were incorrect and contained conflicting information in respect of people's capacity to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. If someone is subject to continuous supervision and control and not free to leave they may be subject to a deprivation of liberty. Training schedules confirmed staff had received training on DoLS and from talking with staff; staff demonstrated an understanding of what constituted a DoLS. We were told, "We spent time talking with the DoLS team and GP. Many people's capacity fluctuates but we identified that some people understood the reason for the locked door and also consented to living here so it was felt a DoLS authorisation was not needed." However, documentation failed to reflect the good practice undertaken by staff. We also found that key pads were used throughout the nursing unit and the front door locked and an intercom system used. One person said that this had prevented them from going out on their own as they used

Requires improvement

Is the service effective?

to. People had not been given the codes. The locked doors and key pads had not been identified as deprivation of liberty. We have therefore identified this as an area of practice that needs improvement.

Registered nurses were supported to update their nursing skills, qualifications and competencies. One care staff member told us that she had undertaken medication training and had annual refresher training. She was aware of the medication protocol and of the actions to follow in the event of a medication error. Another told us that they had received nutritional training and felt more would be beneficial for all staff.

Records showed that people had regular access to healthcare professionals, such as GPs, chiropodists, opticians and dentists and had attended regular appointments about their health needs. People and their relatives told us that when they needed to see a GP this was arranged in a timely fashion. The service has a contract with a local GP practice who had two regular GPs who attend the home routinely and when requested. People felt confident their healthcare needs were effectively managed and monitored. One person told us, “If I’m ever unwell, they always get the nurse for me.”

Requires improvement

Is the service caring?

Our findings

People were positive about the care they received. One person said, "They are quite kind but they do rush around, everything takes so long." Another said, "I'm left alone a lot, pretty bored." Visitors told us, "They speak to residents, seem respectful and the place is clean," and "My husband seems happy enough."

At times staff did interact with people in a caring and respectful manner, but we also observed instances when staff were too busy and did not engage positively with people whilst supporting them. Staff assisted people, but did not ensure their comfort by verbal reassurance or display empathy with people's health needs. During the meal service a staff member came in to the dining room and leant over the table and without a word put a person's false teeth in their mouth. This was done in front of people and the person was very embarrassed. We also observed staff hoisting one person from a wheelchair to a chair during a game of bingo in the lounge. The person's clothing was not effectively covering their body and their thighs were exposed during the process. Some peoples' bedroom doors had glass panels in them. Although there were curtains on the inside of the doors or opaque film applied to the glass, we observed one room where the opaque film did not obscure all of the glass, meaning that the person's privacy was not being protected sufficiently.

Whilst staff were in a room assisting someone the call bell for another room was ringing. As they left the room one staff member said very loudly, "If that's (person's name) I will go mad they never stop ringing." This was loud enough for people in corridor to hear and the person they had been assisting. This did not demonstrate staff showing respect for the person.

Staff told us they promoted people's independence and respected their privacy and dignity. Staff greeted people respectfully and used people's preferred names when supporting them. One staff member commented on how they encouraged people to be as independent as possible. However this was not supported by our observations. For example, one person wanted to go for a walk and staff had to refuse the request because they didn't have the time. This meant that the person became quiet and disinterested in what was happening around them. Another person requested to go to their room, but a staff member said it wasn't time for them to go to their room. We were with a person when they requested to go to the bathroom. A staff member was called and they told the person that they had been to the toilet a little while ago and didn't need to go again. The person repeated that they wanted to go but the care staff member said, "I'm going to take you to the dining room now." This person was not assisted to go the bathroom. On reviewing this persons' record it was documented that this person was continent if assisted and suffered from recurrent urine infections. Urine infections can cause frequency and discomfort and this was not considered by the staff member.

Mais House had long corridors leading away from the dining and lounge area and some bedrooms were some distance away from where staff spent time and the staff offices. People in rooms spent long periods of time isolated with very little spontaneous interaction. Apart from coffee and lunch being given we saw that these people did not see anyone. We spent time talking with one person who said, "I stay in bed because of my illness and it gets very lonely." Another person told us, "I do get lonely but when staff pop in I feel better, I wish it happened more often."

We saw that peoples clothing was not always appropriate. Some clothing was ill fitting and looked uncomfortable whilst other people were dressed in stained clothes following drinks and meals. Staff did not offer a change of clothing or a clothes protector. This had not maintained people's dignity. We visited one person who had been assisted with their midday meal and we revisited them an hour later and they were still wearing a clothing protector which was damp and covered in food. The person was unable to move the protector themselves.

Observations throughout the day identified that staff did not always offer people a choice or listen to what they wanted. People were placed in chairs for long periods without a change of position or being asked if they wanted to sit elsewhere. The television was on in the lounges but people were not asked if that was what they wanted to watch. One person was asking to return to their bedroom but staff told them to stay in the lounge. This had not enabled people to make everyday choices important to them and to meet their identified needs. One member of staff told us, "We can't always do what we should to encourage people to be independent, no time, so we do it for them." When we arrived for our inspection, a number of

Requires improvement

Is the service caring?

the clocks around the service had not been changed to show Greenwich Mean Time, although British Summer Time had ended four days prior to our visit. This did not promote people's independence or autonomy.

People told us they were well cared for. One person told us, "Very nice staff." Another person told us, "I'm happy here." However documentation on when people received oral hygiene, baths or a shower recorded that often people did not receive the care they required. We saw that people could go five days without receiving oral hygiene. The manager informed us, "Care staff should be recording in people's daily notes when a bath or shower is offered and why oral hygiene was not given." The sample of daily notes we looked at did not always record when an individual received care or if personal care was offered. We could therefore not tell if people received regular support to bath or shower. Care staff commented that most people received a bed bath but could not confirm why people were not offered a regular bath or shower. This meant we could not be assured that people's personal hygiene needs were being met. We asked staff if there was a dignity champion on the staff team. Staff were not sure of what a dignity champion was, we were informed later by the manager that there wasn't one at present but this would be discussed and a champion appointed. Daily records in people's care plans were task-focussed. For example, staff had written, "safety maintained," "hoisted onto commode" and "pad changed." There was little reflection of how the person was feeling, whether they were sad or happy.

We were informed that people and families were involved in their care plan. However people we spoke with said, "I am supposed to meet monthly to discuss my plan but it hasn't been happening." A visitor said, "I have asked to see the care plan but I have received delays." There was little evidence in care plans that people had been asked to their thoughts and wishes.

The provider had not ensured that people were treated with dignity and respect in ensuring their personal care needs were met consistently. These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, we did see some staff interacting with people in a kind and compassionate way. When talking to one person who was a little distressed, we saw a staff member sit next to the person and talk to them in a way that had them smiling and agreeing to have a cup of tea." There were staff who had clearly developed rapports with people and people responded to staff with smiles.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's private information.

Requires improvement

Is the service responsive?

Our findings

People commented they were well looked after by care staff and that the service listened to them. One person said, "I think I get everything I need, no problems really." A visitor said, "They deal with things quickly." However, we found the provider did not consistently provide care that was responsive to people's individuality and changing needs in a consistent way.

People's continence needs were not always managed effectively. Care plans identified when a person was incontinent, but there was no guidance for staff in promoting continence such as taking them to the toilet on waking or prompting then to use the bathroom throughout the day. We asked staff about continence management and they could tell us who was incontinent and who required prompting and assistance. However there was no mention of promotion of continence to prevent incontinence. People's continence needs can be managed by regular prompting and responding to body language and timings for drinks and meals.

We saw a person that experienced many problems due to their weight. It stated in the care plan that the person wanted to lose weight to improve their health and well-being. Staff had not discussed a plan for weight loss. The chef was not aware that this person wanted a low calorie diet and had not discussed this with the person. The care plan review stated 'very disappointed that they had not lost weight.' There had been no involvement with a dietician or GP.

Care plans were not being followed by staff on the day of the inspection. We noted that the pre admission assessment for one person had been undertaken 24 September 2015 and stated that the person was unable to communicate their needs. This was incorrect. The person was frail but had full capacity to make decisions and be involved in their care plan formation. This had not happened. The person was admitted to the home on 1 October 2015 without a further assessment of needs on admission. There were no care plans in place to respond to their individual needs such as mobility, nutrition or continence. One entry on life style choices stated the person preferred to wear trousers however we met this person three times and each time they were wearing a skirt. We asked this person if they were able to choose their clothes and they told us "No, staff dress me after they wash me." One person we spoke with had a new weakness to their right side following a stroke, staff had not identified the need for passive exercises to prevent contractures of their hand or thought how to promote their independence with special cutlery and in encouraging them to wash and dress themselves.

Activities were available and were held in the main lounge on the ground floor. However there was a lack of stimulation for people who remained in their room and some people were socially isolated. We visited two people who remained on bed rest for health reasons. They told us they received very little interaction or stimulation and were at times lonely. One person said, "They try hard but don't have the time to just have a chat." A member of staff told us, "There isn't enough for people to do if they stay in their room so they sleep a lot of the time." The activities co-ordinator was working hard to introduce more meaningful person centred activities for people. They also said that it was very difficult on their own to ensure everyone had the opportunity for one to one sessions. During the morning we found people sitting in lounge areas with the television on, but no other stimulation. Many people were asleep in their chairs.

Mais House had two vehicles that had been used to take people out regularly, but this had not happened for some time. One person told us that they missed the trips out and if they visit the doctor or hospital they now had to get a taxi and this had impacted on their independence. We spoke to the manager who informed us that this was being rectified.

The evidence above demonstrates that delivery of care in Mais House was not suited to individual people's preferences and needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the activity person who was enthusiastic and had introduced many good ideas to deliver meaningful activities. They acknowledged that there was still a lot to do to ensure that everybody had the social interaction and lifestyle to enhance their life. We were told that it was difficult to see everyone because their needs were so varied, but two care staff were now joining his team to assist him.

There were celebrations and events held in the home which were enjoyed by the people living in Mais House. We met two members of care staff that were involved in

Requires improvement

Is the service responsive?

activities and events. They were also very enthusiastic and told us of the wish tree. The wish tree is specific to individual personal wishes and staff ensured that this happened for them. One person wanted to go home and spend the day with her husband in their home. This wish had been fulfilled. Another person had wanted to spend the day in Eastbourne and eat fish and chips, this wish had been fulfilled. Wishes for others which are being arranged are Christmas shopping, hot air balloon ride and watching a football match. Photographs of wishes being fulfilled had been taken and were available to see. At present only three people had had this experience but more were being planned.

Before someone moved into the service, a pre-admission assessment took place. This identified the care and support people required to ensure their safety and care needs could be met in the service. The manager told us everyone was visited before any admission. If they felt they did not have enough information to make a decision they requested more. One relative said, “They really seemed interested for my input.” The care and support plans contained information about the needs of the individual. For example, their communication, nutrition, and mobility. Individual risk assessments including falls, nutrition, pressure area care and moving and handling had been completed. These had been reviewed and audits were being completed to monitor the quality of the completed care and support plans.

Complaints were responded to and used to improve the service. The home had a clear complaints procedure that was available to people within the home and from staff if requested. People spoken to said they were able to complain and were listened to. Visitors were also confident that they could make a complaint and it would be responded to. One visitor said “I have complete faith in staff, they listen and act.” Another said, “I would not hesitate to talk to a member of staff if I needed to.” Records confirmed that complaints received were documented investigated and responded to. There was one complaint that had not been resolved and this was now being investigated by the area manager.

Inadequate

Is the service well-led?

Our findings

People told us they liked living at Mais House. Visitors said that although there had been a lot of changes with the members of the management team they were satisfied that the home was okay. One relative said, "I have had concerns, lots of agency staff and not enough staff in the lounges."

The manager had been in post for ten months and had submitted their application to be registered with the CQC. There had been changes to the management team in recent weeks with the introduction of a deputy manager. However we found that the service was not well-led.

Accident and incident reports identified that these were not recorded accurately or responded to effectively to reduce risk in the service. Repeated accidents for one person had not been pro-actively managed. Learning from these incidents had not been taken forward. For example the possible need for further training to reduce the number of injuries and implementation of strategies to respond to people when their mobility deteriorated.

The provider did not have appropriate systems in place to assess, monitor and mitigate the risks relating to people's health, safety and welfare. Areas of concern we highlighted during the inspection had not been identified within any of the service's quality monitoring processes. For example the lack of risk assessments for one person who had been in the service for over a month. We also found that risk assessments for specific important health problems were not reflected in individual risk assessment and that could affect the positive outcomes in the event of a health crisis.

The provider's audit systems had not identified people's risk assessments and care plans were not always accurate. A person's nutritional assessment stated they were not at nutritional risk and it also stated they were not eating poorly and did not lack appetite. This was despite the person having a very low body weight, the persons' own reports that their appetite was not good and care staff confirming that the person ate only small amounts. Additional risk factors due to the person living with a specific medical condition had not been included in their risk assessment. A different person's recently revised care plan stated they were 'immobile.' The care plan made reference to the person sitting out of bed at times during the day. There was no information on how the person was to be supported to get out of bed in either care plan. Care workers told us about different ways in which they supported the person to get out of bed. The provider's audits had not identified the person's care plans had not set out how the person and care workers' safety was ensured when supporting the person to get out of bed.

Medication audits had not identified the errors highlighted at our inspection. Audits for cleaning and for care plans had not identified the shortfalls we found. These shortfalls exposed people to unnecessary on-going risk as identified through this inspection report.

Staff felt their suggestions were not listened to, for example, in relation to staffing levels. The staff meeting minutes identified that staff had raised the issue of staffing levels and staffing levels had not increased or an explanation provided as to why this was not necessary.

Cleaning staff did not have a written daily cleaning schedule, or record of cleaning activities carried out. There were no cleaning checklists in communal areas of the home, such as bathrooms, to provide evidence that regular, routine cleaning was taking place. Domestic staff were unable to provide us with evidence of a sufficiently frequent and regular deep cleaning schedule for the home. The manager was not able to tell us how the provider could be assured that the home was clean and hygienic.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and keep complete and accurate records of was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The culture and values of the home were not embedded into every day care practice. Staff were able to tell us, "We work to ensure that people receive the care they need, the vision is person centred care." Staff we spoke with had an understanding of the vision of the home but from observing staff interactions with people; it was clear the vision of the home was not yet fully embedded into practice as care was task based rather than person centred. Staff mentioned that the two units worked separately and this was a problem at times as it meant there was bad feeling. One staff member said, "We can be really busy on the nursing side and the team on residential side don't help out." Staff said there was a lack of leadership recently and said some nurses seemed 'lost' and that things were not being done as they felt they should. The use of agency nurses has had an impact and this had caused a lack of

Inadequate

Is the service well-led?

leadership on the floor whilst delivering care. We saw a lack of team working. We observed that the two units would not assist each other despite being free. One example was that a person in the communal area was requesting assistance and a staff member from the residential unit said, "I am not looking after you, I will let the staff know you want them." It took 15 minutes for a staff member to assist the person as they had been on their tea break.

People and visitors said that communication and leadership had been difficult and that some changes had not been for the best. In each person's room there was a key worker document that had the manager's name on, but it was a manager previous to the one now in post. The residents' information folder stated yet another managers' name. This meant that people were confused of whom to approach. One person brought this to our attention and also told us that they had not seen their key worker for a long time.

As we saw on the day of the inspection the staff worked hard but there were shortcuts in care delivery due to time constraints and staff shortages. This meant people did not always receive the care they wanted and required.

The provider sought feedback from people and those who mattered to them in order to improve their service. Meetings were used to update people and families on events and works completed in the home and any changes including those of staff. People also used these meetings to talk about the quality of the food and activities in the home. Meetings were minuted and available to view. One person told us that they had raised some issues at the last resident meeting and felt that they had not been rectified. These included the appearance of the cat in the dining room and kitchen, not being introduced to new staff before they appeared to assist them with personal care, lack of staff supervision in the dining room in the evening. There had been an incident where things had been thrown around which had alarmed people. It had also been highlighted by people that there was no support for staff at weekends. We brought these to the managers' attention. The manager said, "We have responded to these but they must have forgotten."

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The provider had not ensured that the nutritional and hydration needs of service users were met. Regulation 14 (1) (2) (a) (b) (4) (d) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had not ensured that service users received person centred care that reflected their individual needs and preferences. Regulation 9 (1) (a) (b) (c) 3 (a) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider must ensure that systems or processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.** **Regulation 17 (1) (2) (a) (b) (c) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Diagnostic and screening procedures Treatment of disease, disorder or injury	The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Regulation 18 (1) (2) (a) (b) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured that service users were treated with dignity and had their privacy protected. Regulation 10 (1) (2) (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (a) (b) (e) (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.