Beaumont Lodge Limited

Beaumont Lodge Nursing Home

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

Summary of findings

Overall summary

Beaumont Lodge Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Beaumont Lodge Nursing Home is registered to provide nursing and personal care for up to 43 people. There were 34 people living at the service at the time of our inspection.

This inspection site visit took place on 7 December 2017 and was unannounced.

There was a registered manager in post however they were on leave on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. We were supported by the senior nurse on the day of the inspection.

Staff were not recognising risks and acting upon them. There were bed rails in place for people without proper assessment around the risk of these. Staff were not always knowledgeable on the risks to people including how to support a person appropriately when they had a catheter and how to monitor food and fluid intake and output.

Medicines were not always being managed in a safe way. People did not always have access to the medicines they needed and medicines charts were not always completed accurately. People were not always protected against the risk of infection as staff did not always have appropriate guidance in relation to this. Accidents and incidents were not always monitored to ensure safety of care.

We saw that there were sufficient staff that were attentive to people's needs. There were elements to the safety of people that were being managed correctly including mobility risk assessments, skin integrity and nutrition. Equipment was available to assist in the evacuation of people and there were personal evacuation plans in place to provide staff with guidance on how to provide support. Robust recruitment took place to ensure that only suitable staff were employed. Staff were aware of how to report abuse and people told us that they felt safe with staff.

Staff had not received effective supervisions and nurse competency had not been assessed. Clinical training had not been provided to nurses and this was reflected in the practices we identified. Staff had not ensured that people had the capacity to make decisions for themselves as appropriate assessments had not taken place.

Although people told us that they enjoyed the food there were not always choices available to people that were on restricted meals. People did not always have the option of a cooked breakfast and a cooked meal in the evenings. We have made a recommendation around this. However people did have access to health

care professionals when they became unwell.

The environment did not always meet the individual needs of people living at the service particularly those living with dementia. We have made a recommendation around this.

People were not offered choices of when they wanted to get up, where they had breakfast and when they wanted a bath or a shower. There were times where people were not respected and had routines without choice. Visitors were restricted to where they could spend time with their loved ones at the service. We did see instances of staff being kind and caring towards people. Visitors were able to come to the service when they wanted. People had access to religious services that were important to them.

Care planning was not specific to the person. Care plans lacked guidance to staff on how to deliver the best care that was appropriate to their needs. People had mixed views around the activities on offer and people in their rooms were not always provided with meaningful activities. End of life care plans did not detail the wishes of the person when they were at the end of their life.

There was a lack of leadership at the service. The registered manager had not ensured appropriate management cover whilst absent from the service. People, relatives and staff were not clear on who the manager was. Staff culture at the service was one of managing workload rather than person specific care.

Quality assurance was not robust and did not identify the shortfalls we found on the day. Where people had raised ideas about improvements this was not always followed. We did find instances where improvements were made as a result of feedback from people. Records were not robust and did not always contain accurate information.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. People told us that they knew how to complain and who to.

People and staff thought that the service was well organised. Staff told us that they felt supported and were asked for their feedback through surveys. There was evidence that the provider was working with external organisations in relation to the care provision.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Staff had informed the CQC of significant events.

The service was last inspected on the 27 and 28 September 2016 where no concerns were identified.

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 safe.

Risks to people's care was not always being provided to ensure people's safety. Medicines were not always managed in safe way. We did see aspects to the safe care of people and storage of medicines.

There were appropriate plans in place in the event of an emergency at the service.

There were appropriate numbers of staff are always available for people.

Robust recruitment checks were in place that ensured that only suitable staff worked at the service.

Staff were aware of how to protect people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were not acting in accordance with the Mental Capacity Act 2005. People's capacity had not been assessed before decisions were made on their behalf.

Staff were not always competent to carry out their role and training was not always provided.

People were not always offered choices around meals. However people told us that they enjoyed the food at the service.

People had access to health care professionals when they needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always have a choice around their care delivery.

The delivery of care was structured around staff work schedules.

Staff did not always treat people with dignity. However we did see occasions where staff were kind and attentive.

There were restrictions on where visitors were able to spend time with their family members at the service. However people's relatives and friends were able to visit when they wished.

Is the service responsive?

Requires Improvement

The service was not always responsive

There were not always sufficient activities for people to be involved in.

Care plans were not written in a person centred way and did not always include guidance for staff around how care was to be delivered.

Complaints were investigated and improvements made where necessary.

Is the service well-led?

Inadequate

The service was not well-led.

There was not adequate management and leadership at the service.

Quality assurance was not always being used as an opportunity to make improvements.

People, relatives and staff felt the service ran well and felt involved in the running of the service. There were aspects to the quality assurance that were used to make improvements.

Notifications that are required to be sent to the CQC were being done.

Beaumont Lodge Nursing Home

Detailed findings

Background to this inspection

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

Some of the people living at the service were living with dementia.

This inspection site visit took place on 7 December 2017 and was unannounced. Due to the concerns we had received we arrived at the Beaumont Lodge at 7am. The concerns that were raised prior to the inspection were around the lack of choices people had about their care and the unsafe use of bed rails.

The inspection team consisted of three inspectors.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is because we were following up on concerns that we received and we inspected the service earlier than planned. The PIR 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.

During the visit we spoke with seven people, one relative and eight members of staff. We looked at a sample of four care records of people who used the service, medicine administration records and training records for staff. We looked at records that related to the management of the service. This included minutes of resident, relatives and staff meetings and audits of the service.

Requires Improvement

Is the service safe?

Our findings

People when asked told us that they felt safe at the service. Comments included, "I do feel safe. If you've got anything to say you would just go to the office and tell them what you don't agree with. I've never had to though", "I've never even thought about feeling unsafe. The staff are all nice and I've never been upset by them" and "I feel safe. There is always someone at the front door. It feels cosy and staff are nice." Despite these comments we found that people's care was not always provided in a safe way.

People's freedoms were not always being respected because staff were not allowing people to take risks. Of the 34 people living at the service 29 had bed rails. We asked a member of staff if bed rails risk assessments had taken place for each person that had them. Risk assessments need to take place as there is a risk of strangling, suffocating, bodily injury or death when people or part of their body are caught between rails or between the bed rails and mattress. Serious injuries can also be sustained from falls when people climb over rails. They told us that they had but they were unable to explain the risks to us. We reviewed bed rail risk assessments. One record stated "Is resident likely to fall from bed?" and the response recorded was, "No." This was also recorded in other fall risk assessments we looked at. On the basis that people were not at risk of falls we asked a member of staff why bed rails were put in place. They told us that this was because the relatives had requested this. We saw one person with their leg hanging over the bed rail. They were repeatedly calling out for staff. We raised this with a member of staff who told us that this was the way the person raised staff attention. They did not recognise that although the person had never attempted to get out of bed they may become entrapped.

People were not always protected against the risk of unsafe care as appropriate measures were not in place. One person had a catheter. The person had been unwell so a decision had been made by staff for them to stay in bed. The person's catheter bag had not been changed to a night bag which was important as the loops of tubing must be higher than the bag to reduce the risk of urine infections. The catheter had been placed on the bed between the person's legs. Staff were not aware of the risks of this and told us that night bags were only used so that staff would not need to disturb the person when emptying the bag at night. On another occasion we identified that one person did not have a call bell when we first arrived at the service. Later on we observed that the person had two call bells in their room. We tried using the call bells and found that one did not work. When we asked staff about this one told us, "She has two call bells, one works and one doesn't because she rings a lot." This meant that the person had no way of alerting staff when they needed assistance.

People's fluid intake and output was not being monitored effectively. There were a number of people at the service that had catheters. Staff were aware to report any changes in the colour or smell of urine. A nurse told us that, "Staff know that 200mls [of urine] should be coming out [of the catheter] when emptied every two hours." However staff were not measuring the urine output. The nurse said, "It's not always possible to get staff to record everything." There were people whose fluid intake was being recorded however there was no target amounts for staff to ensure that people had received enough to drink. Recognising when a person is not drinking enough and helping them to drink more is important to ensure they are well hydrated and to ensure that there are no underlying health concerns.

Risk assessments for people were generic and lacked detail. There was an overall 'risk management chart' in each person's care plan which considered a number of risks and gave them a score. For example 'risk of abuse by others', 'risk of loss of autonomy', 'fire setting', 'nutrition', 'choking' and 'isolation'. The record gave no space for information to be included and it was not clear how some of these risks were assessed. Details of how to manage risks identified were then built into the care plans. However there was a lack of guidance for staff on how to manage the risk. For example one person had a Parkinson disease diagnosis. Their risk assessment stated, "Staff need to ensure he was safe when experiencing any tremors" and "Attempt to refocus my behaviour if I become verbally abusive." The guidance did not state how the tremors affected the person or what the risks were around their behaviour.

Medicines were not always managed in a safe way which put people at risk. One person was supposed to be administered an inhaler once every morning. The medicine administration chart (MAR) stated that on six consecutive days the person did not have this medicine. It was recorded that the person was, "Unable to inhale." The clinical lead had not been informed by staff that the person had not had this medicine and this had also not been communicated to the GP. This was despite the GP visiting the person the day before the inspection. A member of staff contacted the GP when we pointed this out to them. Another person's care plan stated that when they have particular challenging behaviours, "Administer medication when all the above fails to calm me down." At the time of the inspection there was no prescription for this type of medicine. A member of staff told us that they would speak to the GP about this.

We identified that there were MAR charts that were handwritten by staff that had not been countersigned by a second member of staff to ensure that they were accurate. There was a risk that staff could not be certain that people had received their medicine. One of the nurse's signature was recorded as 'N', which could also be mistaken for the coding to say that they had nausea. Another person had a medication patch. Staff were not recording where the patch had been placed on each occasion to ensure that the patch was not being applied in the same place. This should be done as placing a new patch in the same place as the old one may irritate the person's skin. We also identified that there were no 'as and when' medicine protocols in place to provide guidance for staff on when pain relief needed to be offered to people. There was no evidence that staff had undertaken medicine competency assessments to ensure that they were safe with administration of medicines.

The provider contacted us after the inspection to provider us with evidence that one member of staff's medicines competency was assessed. The provider confirmed that all medicine competencies had been assessed for all nurses. However this was not effective in identifying the poor practices that we identified.

People were not always protected against the risk of infection as appropriate measures were not in place. The laundry room was not set up to ensure that there was a designated area for the clean and dirty laundry to be handled separately. There was underwear covered in faeces that had been left loose in a laundry basket. A member of staff then placed a large amount of non-soiled clothing on top of the underwear. We asked a member of staff to address this. A red bin used to place soiled clothing had a person's clean clothing and towels placed around the rim of the bin. One member of staff told us that soiled washing should have been placed in a bag and kept separately from non-soiled items. We reviewed the service's infection policy and there was insufficient guidance for staff in relation to how they were required to store soiled clothing. One of the washing machines had built up dirt and lime scale around the opening and required cleaning.

Staff were not always following good infection control which put people at risk. When we arrived at service we noted that the sluice rooms had bags of clinical waste stored there. We noted that the sinks in the room were dry which indicated that they had not been used by staff to wash their hands. One member of staff told us that staff should be washing their hands in the sluice room. They said that staff did not like using the sinks

in the sluice room so instead would leave the room to wash their hands in a communal bathroom. The member of staff acknowledged that this increased the risk of cross-infection. There were small tears in fabric on one person's bed bumpers which made it difficult to clean and meant bacteria could be harboured. In the downstairs shower room there was a cracked screen and we could see black mould in a crack where it had not been cleaned appropriately.

Records were not always being maintained or updated with accurate information. Where people required to be re-positioned staff were not always recording how often this needed to be or each time it was done. For example one person was permanently cared for in bed. Over a three day period the re-positioning charts were filled in sporadically by staff. There was a risk that staff would not know the last time the person had been re-positioned. There were contradictions in care plans which could lead to confusion over what care was required for people. For example one person's care plan stated under 'Moving and Handling' that they transferred with two staff and frame. However under their DoLS assessment it stated they required full sling hoist. They were assessed as at high risk of developing pressure sores. However there were no re-positioning charts in place for the person despite the fact they were permanently cared for in bed.

Accident and incident forms were not completed with sufficient information. There had been no accidents or incidents recorded at the service since September 2017. Prior to this we saw that when they were recorded there was no detail on the preventative measures taken to ensure they did not happen again. However we were provided with evidence after the inspection of the actions that had taken place. We has asked the provider to ensure that the incidents forms are updated with information on what actions had taken place to reduce further risks.

Failure to safely mange risks to people, poor infection control practices and the poor management of medicines is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were aspects of managing risk that were safe. People had risk assessments around their mobility, their skin integrity and nutrition. There was information for staff on what walking aids people required, whether they required creams to be applied each day and whether they required a soft diet if they were at risk of choking. We saw that staff were following the guidance on these risks. There were areas of medicine management that were safe. The temperature of the medicine room was taken and recorded daily. Dates were written on the medicines to show when they had been opened. MAR charts had a photo of the person and details of people's allergies.

We asked people whether they felt there were enough staff and there were mixed responses. One person said, "Sometimes you might get a lack of attention but not very often. They've got others to see and they come as soon as they're free." Another person said, "I sometimes think there could be more staff. It's not a problem to me. I just feel sorry for them being so busy all the time." A third said, "There's enough staff around." One relative told us there were always enough staff available to meet people's needs when they visited.

Equipment was available to assist in the evacuation of people. Fire exits are clearly marked and free from obstruction and fire evacuation plans were displayed throughout. There were personal evacuation plans for each person that detailed how staff needed to support the person in an emergency. Equipment was tested regularly to ensure safety. Entry to the service was via a locked front door and visitors were asked to sign the visitor's book.The service had a business continuity plan that contained information around what to do if there was a gas leak or lack of water and what staff needed to in the event of a fire or a flood.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. All staff had received safeguarding training and staff were reminded of the safeguarding procedures during meetings with their managers.

People were protected from being cared for by unsuitable staff because robust recruitment was in place. Staff told us about the selection procedure that they went through to ensure that they were safe to start work. Staff told us that they were interviewed for the job and had to provide two references and had to undergo police checks. All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms had been fully completed with any gaps in employment explained. The provider had ensured that staff had the right to work in the country and screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for. Nurses' registration status was also checked to ensure that this was still valid.

Requires Improvement

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

People's rights were not protected because staff did not always act in accordance with MCA. Although staff had received MCA training in 2016 we found that they lacked an understanding of how to put this in to practice. A member of staff told us that at least 18 people at the service lacked the capacity to make a decision about their care. All of these people had bed rails. There had been no decision specific MCA assessment in relation to whether they had the capacity to make the decision. There was no evidence of any meetings to detail how they came to decision that it was in the person's best interest to have them. A member of staff told us that often they would put the bed rails on because the relatives had requested this. However we found that there was no evidence that relatives concerned had the legal right to make these decisions. The MCA assessments for people were generic with blanket statements such as "Reasonable belief service user has not got capacity in relation to this decision." There was no information on what decision they were assessing.

There were people at the service who lacked capacity that had received a flu vaccination from the nursing staff. One care plan stated, "Dr advised to administer the vaccine. No contact received from family. Letter sent and message left over phone. No answer until date. Administered by nurse [name of nurse]." This indicated the vaccine had been given without the consent of the person or their authorised representative.

Where DoLS applications had been submitted to the local authority there was no detail on restrictions people had. This meant the local authority did not have the information they required in order to prioritise the application effectively.

As the requirements of the MCA and appropriate, lawful consent to care and treatment was not sought this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not sufficiently qualified, skilled and experienced to meet people's needs. The training policy stated, "Supervision has three components; management, professional and clinical. Supervision takes the form of regular contact between a supervisor and an employee or volunteer when the employee's performance and practices are monitored and reviewed, and at which the supervisor is able to provide guidance and support and identify areas of work that need development or improvement." One member

said of their supervision, "It is useful, we talk about our policies. Sometimes we have group supervision." Although supervisions took place these were not used as an opportunity to address shortfalls in staff practices. There was no evidence that clinical practices were being reviewed. We asked to be provided with evidence that nurse's clinical competencies were assessed and we were not provided with these. One person told us, "I think they [staff] have the skills for best part of the time but sometimes you wish they had common sense."

We found from reviewing the training matrix that nurse staff were not always up to date with their clinical training. For example pressure ulcer training had not been provided to four nurses since 2007. Three nurses had not received any training in pressure ulcer care. Wound care training had not been provided to three nurses and four had not had this training since 2013. There were long gaps in training in falls prevention, dementia care, blood taking and catheter care which is essential to keep their skills up to date. Although other mandatory training was provided to nursing and care staff they were not always competent in putting this into practice. Particularly around catheter care, MCA and infection control.

As there is lack of staff training, knowledge and competency this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people what they thought of the food. One person said, "I always eat all that's put in front of me so that says something. It's always something different every day and you can choose." Another person said, "The foods nice, always well cooked." A third told us, "The food is okay." A fourth said, "Lunch is very good. There is a variety of stuff. Nice portions and I always have a drink." One relative told us, "[My family member] likes the food. There's a choice."

However, people did not always have choices in relation to meals. There were people at the service that were on restricted diets. The chef told us that people that were on a soft or pureed diet were not given choices of a meal and that they pureed or mashed the meal that they thought was most appropriate. One person was on a vegetarian diet and this person was also not offered a choice of meal. People were asked when they moved in what they liked for breakfast. One person told us, "I like egg and bacon but I have never been given egg or bacon." The chef told us that breakfast options were porridge and/or toast and that people were not given the option of a cooked breakfast. There were people that were able to have breakfast in the dining room however other people were not given this option. Breakfast was delivered to their rooms. At lunchtime people were provided with a freshly cooked meal however in the evenings people were offered pre-made sandwiches. The alternative for the evening meal on the day of the inspection was hot dogs with buttered bread.

The service used pre-made meals that looked and smelled appetising and a choice of two options were available at lunchtime. We observed people having their lunch in the dining room and the lounge on the day of the inspection. Tables were nicely laid and there was a pleasant chatter between people. People that were not on a restricted diet were offered a verbal choice. We saw pureed food was nicely presented. Staff were available to help people when needed. We observed one person saying to a staff member that they needed some help and a member of staff immediately got a chair and went to support them. People in their rooms were not left to wait for their meals. The provider notified us after the inspection that they will ensure that all people regardless of their diet will receive choices and that people will be made aware of the choices on offer.

We recommend that people are provided choices about what they eat and are supported to maintain a balanced diet.

The environment did not always meet the individual needs of people living at the service. There were very few destination points or signage to help orientate people living with dementia around the service which would assist them with their independence. There were no areas of stimulation or destination areas for people to be involved in. Keeping the person who is living with dementia active and engaged can help discourage wandering behaviour by reducing anxiety and restlessness.

We recommend that appropriate signage and adaptations are made to the premises to ensure that people's needs are met and their independence is promoted.

People were allocated a key worker to provide their support. One member of staff told us of their key 'residents', "I know them the best. They trust me. I visit them every day. You can gain trust from them." Another said, "We have responsibility for their care, for communicating with the families." Care records showed appointments with health professionals were updated and contained evidence of GP, Speech and Language Therapist, opticians, dentist and podiatry. One person told us, "They call the doctor if you need it. If you've got a cold you can stay in your room and they'll bring your lunch up." There was evidence that one person had been referred to healthcare professional when they displayed behaviour that challenged staff. The healthcare professional had assessed the person and written to the person's GP requesting an increase in medicines. A member of staff told us that as a result the person no longer displayed behaviour that challenged. Another person had been referred to the dietician as they had been losing weight. As a result the person had gained weight and their risk of malnutrition had reduced.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that staff were kind towards them. Comments included, "We are so happy with this home, it's lovely", "[Staff are] very good and nice. They help you" and "Staff are nice", "The staff are nice, I've no complaints about them", "I like it here. It's nice and friendly"; "I'm content here. There's no place like home but it's alright. They're nice to me so I can't ask for anything more."

Staff were well-intentioned however there were routines and practices in place that resulted in poor standards of care and restricted people's choices and independence. When we arrived at the service at 07.15 people had already been woken to give them breakfast in bed. There were people asleep in their beds with the light on. Staff confirmed to us that part of the duties of night staff was to ensure that people were woken to give them breakfast at 06.30. They said that the lights were left on in preparation for them receiving personal care from staff. We heard one person calling out for assistance. They were in bed with their breakfast on a tray in front of them and looked dazed and confused. The person told us they had been woken to have their breakfast. Another person said, "I get up when they tell me. I've always been an early riser though." A third person told us that they got woken up every day. One member of staff told us that the reason people were being woken up was, "To do with the workload" which meant that people were not given choices and that this was about staff managing their workload. Prior to having their breakfast people were woken to have their continence aids changed rather than staff doing this when it was needed.

There was a sign up by the front door stating, "The residents will be having a quiet period where there will not be any activities taking place. Please be as quiet as possible between these times (13.30 – 14.30)." We found the 'quiet time' was done without giving people a choice. At 13.30 the television was turned off. Staff told us that if people did not want this 'quiet time' then they could go back to their rooms. One member of staff told us that 'quiet time' was also used as opportunity for staff to go on their break. We observed this 'quiet time' and although three people chose to go to sleep in their chair (and a member of staff was present) there were nine people that were awake and happy to talk to us. No one was asked if they wanted this 'quiet time.' One person told us, "I don't suppose I mind [the quiet time]. I do try to have a sleep but I'm a very light sleeper and someone always makes a noise. It's not as though I'm doing anything all day to need a sleep though." We found the enforced silence in the room during the 'quiet time' uncomfortable.

People were not given choices of when they wanted a bath or a shower. We found that 'bath and shower' days were allocated to people. One person said, "They [staff] don't ask. It's just done. In the summer when it's warm it would be nice to have a shower every day." One member of staff told us, "We have an allocation. The day is fixed for them." We asked what would happen if people wanted additional baths/showers or wanted a bath/shower on a different day. They told us, "It depends on the situation. We will have to talk to the nurse and maybe we can arrange it." People were not all given the options to have their drinks from a glass or a china mug. The majority of the people were given plastic cups with funnel lids and a straw. One member of staff told us that this was the way they had always offered people drinks. There were people who would have been able to use a glass or a china cup but they were not given this option.

People were not always treated with dignity or respect. Examples included one person who had a lot of

furniture being stored in their room. A member of staff told us that furniture was being stored in there because they were decorating the room next door. There was no evidence that the person had been consulted or asked if they were happy with this arrangement. During lunch we heard one staff member shout across the room to another member of staff, "Will she feed herself?" The staff member relied, "No, you'll need to feed her." The staff member then left the person for a few minutes before returning to support the person. Staff calling across the room in this way was undignified for the person.

People did not always have choices where their relative could spend time with them at the service. We were told by staff that visitors were not allowed to go in the lounge where people were sitting. Instead people were brought to their relatives in a different room. The member of staff told us that this was because there were people at the service that had no visitors and that this may not be fair to them seeing other people with relatives visiting. Staff did not consider that people seeing visitors could brighten their day for them. There was a risk that people were being socially isolated by not seeing familiar faces visiting the service.

The provider contacted after the inspection and provided assurances that these practices by staff had been addressed. They advised us that people would be given choices around where they wanted to spend time with their visitors and that the 'quiet time' had ceased. We will check this at the next inspection.

As people did not always have choices around their care delivery and were not always treated with respect and dignity this is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see instances of staff being kind and caring towards people. Examples included one member of staff gently speaking to a person who was in bed asking them if they wanted a drink. Another person was calling out for staff and a member of staff reassured them and tended to their needs. The member of staff said, "It's ok [person's name], it's only me, relax those arms, now that's better. How are you?" Another member of staff was seen chatting and singing with another person who was in their room. When bringing one person into the lounge staff took time to ensure they were comfortable and asked if they need another cushion. A person introduced us to their keyworker. There was a genuine affection between them. The person joked about 'sacking' the member of staff who laughed and said "Oh you wouldn't do that, we're friends."

There were instances where people's dignity was respected. When personal care was provided this was done with the door closed. When staff went into people's room they knocked beforehand. One person told us that staff asked them what they would like to be called when they first moved in. Another person said, "They [staff] automatically draw the curtains and shut the door." One member of staff told us, "We have to keep the dignity; we treat them as our own family." People did have the opportunity to practice their religion. There was a list on the staff notice board of dates for monthly church service. Two people also had a weekly visit from a priest to receive holy communion.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not personalised and lacked daily routines specific to each person. Although pre-admission assessments were undertaken these did not contain sufficient information to make an informed decision about people's needs. A member of staff told us that limited information was known about a person who had recently been admitted to the service. We confirmed this from reviewing their pre-admission assessment. It was not clear how staff at the service were confident that they would be able to meet the needs of the person before they moved in. The member of staff told us that the person had displayed behaviours that challenged. They said that this could be as a result of them moving in but detailed assessments of the person's needs before they moved in may have enabled the service to identify this.

There was evidence that people were not always consulted in their care. There was a statement in each care plan stating, "The use of the word 'I' in my care documents is not used only to indicate my actual spoken requests what my named nurse, acting in my 'best interests' have judged I would request following discussions with my family, advocates and other significant health professionals. My named nurse's judgement is also based on observations, any significant past history and my current abilities and limitations." A member of staff told us that they used the term 'I' even if the person had not been consulted. We saw examples where staff made choices for people yet the care plan indicated it was the person's choice. For example, one care plan stated, "Make sure I have the number of pillows I have requested" and "I have requested bed rails be applied to my bed as they provide me with a sense of security and comfort." A member of staff confirmed that the person had not been consulted in relation to this, and did not make these statements.

There was a risk that staff did not have the most appropriate guidance in relation to the support they were required to give. One care plan stated, "I encounter difficulty making myself understood as I don't speak English. Staff to use short sentences which only require yes or no answers." There was no guidance or alternative communication systems used. Routines recorded for people were identical particularly in relation to 'personal care', 'cognition', 'mobility' and 'sleeping'. Standard phrases were used and there was a lack of personalisation. There were people that had diabetes. There was no guidance for staff to look out should the person's blood sugar levels become too high or too low. One person had epilepsy and although they had never had a seizure whilst living at the service there was no guidance for staff on what they should do if one occurred.

We reviewed the end of life care plans for people. These lacked detail around what the person's wishes were should they require end of life care. For example one person had an advanced care plan in place which stated that they wished to be actively treated in hospital. There was no other detail regarding their preferences or their past wishes. No one at the service was receiving end of life care at the time of the inspection.

We asked people about the activities at the service. One person said, "Sometimes they have things on. I like to sit in my room though. I'm quite happy in here." Another said, "They're very good. We have bingo and crosswords. Entertainers once a month." A third said, "There's quite a lot going on. I'm never bored."

However another said person told us, "I get fed up here, it's different when you're at home. It's all a bit boring really, mainly bingo but old people like that I'm told." A sixth person said, "Its [activities] alright. Sometimes better than others."

We were told by staff that activities did not occur at weekends as there were lots of visitors that came to the service. However this did not account for the people that did not have visitors coming to see them. There was an activities coordinator recruited at the service. During the inspection we found that they undertook additional duties that took them away from their activity role. Whilst staff were providing care to people in their rooms in the morning we saw the activities member of staff supporting people in the lounge. We observed five people sat with the activity coordinator doing a Christmas crossword and all people were engaged with this. However other people spent their morning in the lounge with no activity apart from the television being on. In the afternoon there were people who went out to the local garden centre. There was little going on for people left behind. One member of staff told us that the activity coordinator went round to visit people in their rooms in the morning. However, this did not happen during the inspection.

Care and treatment was not always provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints and concerns were taken seriously and used as an opportunity to improve the service.
We asked people if they knew how to make a complaint. One told us, "I have no complaints. I'd just tell the staff." Another person said, "I would go and see whoever is in charge if I had a complaint." A third said, "I would go and find a manager to complain." One relative said, "I always speak to the nurses if I've got a concern." There was a complaints policy available at reception. We reviewed the provider's complaints log and there were four complaints recorded. In each case the provider had investigated the complaint, resolved the issue and responded appropriately to the complainant.

Inadequate

Is the service well-led?

Our findings

There was a lack of leadership at the service. At the time of inspection the registered manager was on leave. No steps had been taken by them to ensure that there was appropriate management in place during their two week absence. There was no deputy manager at the service and management decisions were being made by the senior nurse. People and relatives were unable to tell us who the registered manager was. People either referred to the provider or the nursing staff as the managers. One person told us, "I couldn't tell you [who the manager is]. There must be someone here to keep things running though." Another said, "Don't ask me his [the provider's] name but I've met him." One relative told us when asked if they knew who the manager was, "I spoke to him [referring to the provider] when Mum moved in but not since. I've got his mobile number if I need it though." Staff also perceived the service to be managed by the provider or the senior nurse on duty. One member of staff said, "He [the provider] always takes action if we need something." Staff differed in their responses around how often the registered manager was at the service. Their answers varied from three days a week to everyday.

The provider advised us after the inspection that a new registered manager was being recruited to the service.

Staff attended meetings and we confirmed this from records. One member of staff told us, "We go through policies, where we have to improve, what we have done good." We saw that staff had been asked to complete satisfaction surveys in 2016 and all of the feedback was positive. 100% said 'management lead by example', 97% said 'supervision constructive', 97% said 'good' or 'quite good' to the questions 'Do you have all the training you need for your role?' and 'Are you supported by your line manager?'

However we found that that there was a staff culture at the service where the care they provided was 'to people' rather than involving them. Most of the staff had worked at the service a number of years. The registered manager had not set the right example for staff to follow. We identified through this inspection institutionalised practices that were more about the steady work flow rather than individualised care including people being woken up for personal care, woken for breakfast, enforced 'quiet time' and scheduled baths and showers.

There were insufficient quality assurances in place to ensure the best delivery of care. Although surveys had been undertaken with relatives these were not always used to make improvements. Relatives were on the whole very positive in their feedback however we saw from one survey in 2017 that a relative had fed back as a suggestion for improvement: "Maybe a little more to do at weekends when no visitors." This concerns was identified on the day yet no action had been taken to address this. When audits were completed these had not identified the shortfalls that we had identified. A care plan audit in September 2017 had not identified that lack of person centred care planning. Poor infection control practices by staff had not been identified through audits. The last 'infection control audit' completed in November 2017 scored 100%.

As there was a lack of leadership, systems and processes were not established and operated effectively this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite our findings people, relatives and staff were positive about how the service was run. One person said, "It's all very well organised." A relative said, "They run a tight ship here." One member of staff said, "We have good teamwork. We are like a family." People and relatives said they were involved in the running of the service. One told us, "They have residents meetings. They just talk about things in general and you can say if you don't agree with them." Another person said, "I go to the residents meetings. They tell us what's going on. Keeps us up with times."

There were occasions where feedback from people was used to make improvements. 'Residents' meetings were held each month. People were asked for their comments about the care they received including the food, activities and housekeeping. The feedback recorded was positive about these areas. One person said they did not like the cheese provided. This had been recorded as a complaint and action taken to resolve this.

There was evidence that the provider was working with external organisations in relation to the care provision. For example the provider had regular contact with the GP, SaLT, dietitians and other community care teams.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Staff had informed the CQC of significant events.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care and treatment was provided that met people's individual and current needs.

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 people had choices around their care delivery and that people were always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that the requirements of the MCA were appropriate and did not ensure that lawful consent to care and treatment was sought.

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 failed to manager risks to people, there was a lack of infection control and there was a poor management of medicines.