HC-One Oval Limited

# Bereweeke Court Care Home

## Inspection report

Bereweeke Road
Winchester
Hampshire
SO22 6AN

Tel: 01962878999

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Bereweeke Court is a care home which provides nursing dementia care and residential dementia care. The service can accommodation up to 50 people. The home is located in a residential area close to community facilities. At the time of the inspection there was 30 people living at Bereweeke Court.

People's experience of using this service and what we found
Risks relating to people's care and support had not been adequately assessed or planned for. There were insufficient numbers of experienced staff deployed at all times to ensure people's safety. Overall staff followed a safe process for the storage and disposal of medicines, but we did find some areas where best practice frameworks needed to be embedded further. There were systems in place to learn from when things had gone wrong. The service was visibly clean, and no malodours were noted. Staff had a positive attitude to reporting concerns and about not tolerating poor care.

Staff had not undertaken all the training they needed to keep their skills and knowledge up to date. Care plans did not consistently cover all the required areas or contain an appropriate level of detail to support staff to deliver effective care or to meet identified needs. People were served meals that were in line with their dietary requirements. However, staff were not adequately monitoring known risks associated with people's hydration and nutrition. The meal time experience needed to be improved to make it a more person-centred and positive experience for people. Legal frameworks regarding consent were not fully met and people were not always supported to have maximum choice and control of their lives and staff and the systems in the service supported this approach. People had access to a range of health care professionals.

More needed to be done to support people with expressing their views and to be involved in decision making. People told us that staff were kind and caring and treated them with respect. However, some of our observations indicated that staff did not always provide care and support in a person-centred manner and there were missed opportunities for staff to engage with people. People were supported to have a comfortable and pain free death.

Care was often task focussed and there was limited interaction with people outside of completing care tasks. Staff told us they did not have time for this. We were not assured that people's individual preferences and needs were being met. People were not being provided with sufficient opportunities to take part in meaningful activities. People and their relatives mostly expressed confidence that they could raise any issues or concerns with any member of staff or the registered manager and that these would be addressed. There was some evidence that the service was complying with the Accessible Information Standard. People were supported to have a comfortable and pain free death.

Feedback about the registered manager was generally positive. Tools used to assess the quality and safety of the service had not been consistently used to help identify areas where quality of care was being compromised and to drive improvements. The provider was taking action to address this. We were not

reassured that the feedback from people and their relatives was always being acted upon effectively. Local health care professionals told us they had open and collaborative working relationships with the service.

Rating at last inspection
The last rating for this service was 'Good' (March 2017).

Why we inspected
This was a planned inspection based on the previous rating.

We found four breaches of the Regulations. You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

**Is the service caring?**

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

# Bereweeke Court Care Home

**Detailed findings**

## Background to this inspection

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

Inspection team
The inspection team on the first two days consisted of two inspectors. On the third day, the lead inspector was joined by a specialist nurse advisor.

Service and service type
Bereweeke Court 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not present during the inspection. The inspection was overseen by a 'Turnaround Manager' who had been assigned to support the service make improvements. They had been in the service for three weeks when we inspected.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service including previous

inspection reports and notifications received by the Care Quality Commission. A notification tells us about important issues and events which have happened at the service. The provider had not been asked to complete a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make.

During the inspection
We spoke with 12 people who used the service and with two relatives. We spoke with the turnaround manager, area quality director and regional director. We also spoke with the deputy manager, one permanent registered nurse and two agency nurses. We also spoke with five care workers, two members of the housekeeping team, the maintenance person and assistant chef. We reviewed the care records of seven people in detail. We also looked at the records for four staff that had been recruited since our last inspection and other records relating to the management of the service such as medicines administration records, audits and staff rotas.

After the inspection
During and after the inspection, we obtained feedback from three health and social care professionals who worked closely with the home.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as 'Requires improvement'. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● People told us they felt safe. Relatives also felt their family member was safe. One said, "I do feel she is safe and secure… They are really concerned for their safety".

● Whilst people told us they felt safe, some of the risks relating to their care and support had not been adequately assessed or planned for.

● One person living with insulin dependent diabetes did not have a diabetic care plan. They and a second person did not have a specific treatment escalation plan to determine how staff should respond in the event of their blood glucose levels becoming too high or too low. Without this there is a risk that the person might not get the specific care they require.

● Some people required air filled, pressure relieving mattresses, to help prevent skin damage whilst they were cared for in bed. On day two of our inspection we found that three out of four mattresses checked were set incorrectly. This would have limited their effectiveness at providing pressure relief. The provider's own recent checks had already identified this as a concern and had linked this to a spike in skin integrity concerns.

● We saw multiple examples where staff had signed a form multiple times a day to say they had checked mattresses were set to a setting. However, these mattresses did not have such a setting. We could not be confident therefore that these checks were being performed correctly or that staff understood why they were completing these.

● After day two a process was put in place to ensure the mattresses were at the right setting, but on day three of the inspection out of 17 mattresses checked, six were still set incorrectly. We did not identify that there had been any actual impact on people from using the incorrectly set mattresses but remained concerned that this presented an ongoing potential risk to people.

● Whilst nationally recognised tools were being used to assess people's risk of poor nutrition, records did not consistently provide assurances that food or fluid intake was being robustly monitored, or that action was being taken in response to low intake, despite the provider's systems requiring staff to reflect on this daily.

● We saw two examples, where people were losing weight, but despite this, the frequency with which they were being weighed had not been increased.

● Two people were observed to be eating their meal in an unsuitable position. This could have increased their risk of choking. One person was known to be at risk of choking and required a modified diet.

● One person's choking risk assessment stated that they should be 'Monitored when taking fluids'. We observed that this person had been left with drinks within reach.

● Two people had catheters, their catheter care plans stated that their urinary output should be monitored

but staff were not following this guidance. There was no evidence that poor urinary output was being escalated to the nursing team in order that this could be clinically reviewed.
● One person's alarm mat, used to alert staff they were mobilising, was found to not be working. Staff were not aware this was not working. We brought this to the attention of the turnaround manager who agreed to ensure that a full audit of all sensor mats was completed.
● There had been a failure to provide a timely response to actions resulting from a fire risk assessment of the premises in October 2018. For example, this risk assessment had recommended that an additional compartmentation survey be carried out and that a fire door be replaced. These actions were assessed as needing to take place within six months to ensure the fire risk rating for the service remained tolerable. These actions had not been completed. The provider has shared with us documentation that shows quotes have been requested for these recommendations to be completed. We will follow this up to ensure this work is completed.
● Personal emergency evacuation plans (PEEPs) were in place but did not reflect the needs of the people within the service. This could lead to a delay in the fire service completing a safe evacuation of the service.
● On the first day of our inspection, we found concerns regarding fire safety in an unused area of the home. A wing of the first floor had not been used for approximately 18 months and was being used for storage of combustible material such as paperwork, cardboard and a large number of incontinence pads. One of the fire doors in this area did not fully close as it was not sitting on its hinges properly. The fire exit route from this area was obstructed by a stair gate which had fallen into the stairwell leading to the fire exit. Whilst no-one was residing in this area, we were concerned that it could present an increased fire risk to the premises. We pointed out our concerns to the management team who took immediate action to remove the combustible materials.

The failure to assess and manage risks to people's safety was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

● Some risks were well managed, and it was evident that some thought had been given to these and people's wishes considered. For example, one person had a risk assessment regarding their wish to use a hot water bottle. Another person had an assessment regarding their risk of reoccurrence of dislocation of their hip. Where bed rails had been recommended as a safety measure, these were observed to be in place and relevant risk assessments completed.
● Post falls observations were mostly, although not always, undertaken for the recommended period to help ensure that any adverse effects from the fall were identified in a timely manner.

Staffing and recruitment
● There were insufficient numbers of staff deployed at all times to ensure people's safety and to respond to unforeseen events.
● On day one of the inspection, there were regular and extended periods of time when there were no staff in the communal lounge on the ground floor. Three of the people present had been assessed as being at high risk of falls and had chair sensor alarms in place. On one occasion, the inspector had to intervene to try and prevent one of these people from slipping from their chair. This was not possible, and the person slipped to the floor.
● We raised our concerns with the turnaround manager who told us the communal lounge should always be supervised, however, we observed similar concerns on day two of our inspection.
● Staff allocation sheets did not provide assurances that each shift had a suitable mix of skills and experience. For example, none of the daily allocation sheets for November 2019 had a fire warden, a first aider, a mealtime champion or dignity champion designated.
● People gave us mixed feedback about staffing levels. Some felt that their needs were met promptly.

However, one person told us, "Some staff are very good, some are rubbish, you press your bell they might come, or they might not" A relative told us, "There is usually staff around, usually someone passing through or helping people in their rooms".

● Staff also gave mixed feedback about staffing levels. One staff member said, "Sometimes there are not enough staff, it's not good for the residents". They told us that when shifts were short staffed, tasks such as showers did not take place or repositioning was delayed. Another staff member said, "We need to stay in the lounge, but it is not possible, we are doing our best".

● Most staff felt that if there were seven permanent and experienced members of staff were on duty, this was sufficient to manage the completion of care. However, rotas showed that agency care staff and agency registered nurses were required daily to fill gaps. One staff member said, "Agency staff are not doing paperwork properly, four of the seven staff yesterday were agency". A second staff member said, "Enough staff? - no, no no, we are really struggling some days, its really hard to manage, to many agencies".

● Staffing levels were calculated using a dependency tool. The provider and leadership used this to guide and inform decisions about staffing levels and we saw examples where staffing had been flexed in response to changes in occupancy and levels of dependency. Call bell response times were tested daily as part of the managers 'walkaround' and poor response times discussed with staff. However, despite these measures, we were not assured that staffing was always safe and enabled staff to respond to people's needs in a timely manner.

There were insufficient numbers of staff deployed at all times to meet people's needs safely. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

● The provider was working hard to recruit and reduce the number of agency staff required and wherever possible regular agency staff were used to help provide continuity of care for people.

● Staff had been recruited safely, and appropriate checks were completed.

Using medicines safely

● We observed people receiving their medicines. This was managed in a person-centred manner.

● Overall staff followed a safe process for the storage and disposal of medicines, but we did find a small number of opened liquid medicines with no date of opening recorded. In the homely remedies we found that one medicine with a shelf life of six months once opened had not been discarded even though it had been opened on 20 December 2017. Similarly, a second medicine with a shelf life of two months had not been discarded even though it had been opened in January 2019.

● Each person's medicines administration record (MAR) contained all the information needed to support the safe administration of their medicines. These were fully completed, with no gaps, and therefore provided assurances that people received their oral medicines as prescribed.

● Overall there was individualised and specific guidance in place to support the administration of 'PRN' or as required medicines and staff were recording the reason why PRN medicine was required. This is useful to help staff identify any themes or trends that might require a review by a health care professional. However, we noted that in the case of one person, their PRN protocol for the use of emergency epilepsy medicines contained conflicting information to that written on their MAR.

● In line with local health protocols, staff were not aware of the need to calibrate glucometers used for measuring blood glucose levels to ensure these remained accurate.

● The registered nurses did not display a thorough knowledge of best practice regarding the administration of insulin. For example, they were not recording the site of administration.

● Pain assessment tools were being used regularly to help staff identify untreated or unmanaged pain in people who were not able to express this.

● Topical medicines administration records (TMARs) did not consistently contain sufficient information regarding the frequency with which, and location, topical medicines needed to be applied. The majority of TMARS viewed contained gaps, but as the prescriber's instructions were not clear, we could not be certain whether this was an administration concern or not.

Learning lessons when things go wrong

● There were some systems in place to learn from safety events.

● Daily 'Flash meetings' were held during which all heads of department came together to reflect on current issues such as any new incidents or accidents that might have occurred, staffing changes or new admissions to the service.

● Accidents and incidents which affected people were recorded and monitored through an online system. Reports were generated monthly which enabled the registered manager or leadership team to look for themes or trends which might require remedial actions to be taken.

● We reviewed the incidents and accidents for September and November 2019 and found instances where appropriate actions had been taken in response. For example, following a fall in an area of the home, the environment had been reviewed and an additional secure door put in place to prevent mobile people from accessing this area of the home independently.

● Root cause analyses had taken place for significant incidents such as deteriorating pressure ulcers and bone fractures.

● We did see a small number of incidents where the investigation had not been sufficiently probing and therefore did not provide reassurances that all opportunities for learning had been utilised.

Preventing and controlling infection

● During our inspection, we observed that the service was visibly clean, and no malodours were noted.

● People and their relatives also felt the home was kept clean. One relative said, "I do think it smells nice, her rooms is always spotless".

● Cleaning schedules were mostly fully completed. We did note that the cleaning schedule for the suction machine had last been completed in June 2019 and brought this to the attention of the turnaround manager.

● Staff told us they often ran short of personal protective equipment [PPE] such as gloves, aprons and wipes. One staff member told us, "If you have spent your budget, you're not allowed them [PPE], you are then scratching round for them. They have come in now, but this can happen often. We can't operate without the equipment".

● Staff were seen to follow good infection control practices, but we have recommended that the care plan for one person carrying a 'Superbug' infection be made more specific and detailed.

● The kitchen was noted to be clean, relevant food hygiene records had been completed and the service had been awarded a food hygiene rating of five, or 'Very good', in June 2018.

● However, there was a fridge in the upstairs lounge in which we found a number of opened food items which had not been labelled with the date they had been opened. One of these items, a yoghurt had a use by date of 20 November 2019. We brought to the attention of the management team who are to review the use of this fridge.

Systems and processes to safeguard people from the risk of abuse

● The provider had appropriate policies and procedures which ensured staff had clear guidance about what they must do if they suspected abuse was taking place.

● Staff had a positive attitude to reporting concerns and about not tolerating poor care.

● Staff were confident that any concerns raised would be acted upon by the registered manager to ensure people's safety.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At the last inspection this key question was rated as 'Good'. At this inspection this key question has deteriorated to 'Requires improvement'. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

● The registered manager and provider had not ensured that staff had undertaken all the training they needed to keep their skills and knowledge up to date. For example, 28% of staff did not have in date 'Safer people handling training'. The provider's own checks had identified that the prevalence of bruising or skin tears was above average and to assess this further they were arranging for a moving and handling trainer from head office to visit the service and mentor staff.
31% of staff did not have in date 'Emergency first aid' and 22% of staff did not have current safeguarding training.

● Whilst a programme of clinical training via the Royal College of Nursing i-learning platform was available. The service was not able to provide any evidence that the registered nurses had yet completed any training in clinical skills.

● Staff did not have training in healthcare tasks such as catheter care or the management of chronic health conditions such as epilepsy or diabetes. The service was caring for people who lived with both these conditions.

● Ten staff did not have training in caring for people living with dementia despite the service caring for a high number of people living with this condition.

● The homes website stated that the specialist care categories supported at the home included Parkinson's Disease. Training records indicated that none of the staff had training in this area.

● Only one of the staff administering medicines had had their competency to do this safely assessed. This was not in line with the provider's policy or best practice guidance.

● Staff were not having regular supervision or appraisals. These processes are important to help develop and motivate staff, review their practice and ensure they understand their responsibilities.

● Following the inspection, the provider told us they had found additional supervision records, but upon review, these still did not demonstrate that staff were having supervision in line with the provider's policy which stated there should be a minimum of four supervisions a year. One staff member told us, "I do miss it [Supervision], they [Managers] need to know what is going on, it helps to improve things".

Whilst staff told us they felt able to approach the register manager for support and advice if needed, we were concerned that the shortfalls in training and the lack of formal and regular oversight of the staff team was a contributing factor to some of the concerns and failings found throughout this report. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Before providing a service, assessments were completed to establish people's needs and to ensure these could be fully met. These were used to develop a range of care plans that covered areas including, personal care, continence care, nutrition, skin care, sleeping, activities and communication. One person who was living with epilepsy had a care plan regarding this.

● However, care plans did not consistently cover all the required areas or contain an appropriate level of detail to support staff to deliver effective care or to meet identified needs. For example, care plans around the management of behaviours which might challenge were simply a description of the behaviours but did not contain any guidance for staff on how these might be best managed or prevented. One person did not have a diabetic care plan despite being on insulin to manage this long-term condition. Another person had significant leg contractures, but the guidelines from their physiotherapist were not captured within a specific contracture plan.

● The care plans were hand written and in many cases were extremely difficult to read.

● Care planning and support was not always in line with guidance or evidence-based practice. For example, a registered nurse was not aware that one of the air mattresses being used required an adjustment to the setting dependent upon whether the person was sitting or lying. This was also not reflected in the care plan.

● Urinary catheters can present a high risk of causing sepsis if not properly managed. Guidance from the Royal College of Nurses advocates a specific training programme for care staff on catheter care. This was not currently in place. The care plans for two people with urinary catheters in situ were not robust and did not include the possible early signs of urinary sepsis.

Supporting people to eat and drink enough to maintain a balanced diet

● Most people commented positively on the food provided. One person said, "The food is nice and hot". A relative said, "Food is not bad, they changed the menu earlier in the year, simplified it, mum seems to enjoy it".

● We observed the lunch time meal during our inspection and found that this needed to be improved to make it a more person-centred and positive experience for people.

● There was no ambience or atmosphere to the mealtime service.

● In one dining area, three tables had been set with cloths, cutlery, serviettes and condiments. However, just one person was invited to come at sit at these tables. A further seven people were not offered the opportunity to come to the table and were given their meal in the lounge in their armchairs.

● Some staff interacted very little with the people they were helping to eat and drink. One staff member was observed to feed a person from one side when the person's face was pointing in the other direction.

● Staff did not consistently describe to people what they were eating or drinking. Upstairs once the first course had been served, the staff left the dining room and gathered in the corridor chatting. This was a missed opportunity to engage with people. They only returned to serve puddings. On the third day of our inspection, two staff were observed to be discussing their own travel and career plans whilst supporting people to eat and drink.

● Due to availability of staff, one person had to wait 45 minutes for their dinner whilst watching everyone else in the room having theirs.

● One staff member did not understand how to correctly add thickener to people's drinks. This created a risk of the drinks not being made to the correct consistency. We brought this to the attention of the deputy manager.

● People were served meals that were in line with their dietary requirements and the elements of pureed meals had been pureed separately to allow the person to still taste the individual flavours.

● Adapted cutlery and plates had been made available for those that needed this.

Adapting service, design, decoration to meet people's needs

● Bereweeke Court is a purpose-built nursing home arranged over two floors.
● Rooms varied in size, some were ensuite and were furnished with people's personal items to help create a homely feel.
● Each floor was split into two wings. On the ground floor there was a main lounge / dining area and a smaller quiet lounge. There was a second lounge and smaller dining area on the first floor.
● Bathing and shower facilities were available on both floors. An assessible and secure garden was available and allowed people living with dementia to continue to safely enjoy outdoor spaces.
● Signage was available to support people living with dementia to recognise and access toilets and bathrooms. Rooms had a photo of the person on the door and there were memory boxes inside, helping people to recognise their rooms. Handrails in the corridors continued to be painted in a contrasting colour to the walls to help make them easier for people to view.
● However, there were areas of the home which looked tired and worn and in need of renovation. For example, in some bedrooms, paint was peeling from the walls exposing the plaster underneath. Some of the beds and bed bumpers were worn exposing areas which could harbour bacteria and present an infection control risk.
● The senior management team told us that the provider had approved a substantial financial investment in the home to help ensure that the home provided a pleasant and homely environment. We asked for further details of this, but this was not provided.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible".

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● Mental capacity assessments had been undertaken to ascertain whether people could consent to aspects of their care and support such as medicines management or consent to photographs.
● The use of covert medicines (giving medicines to people without their knowledge) was taking place in the context of existing legal and good practice frameworks including the Mental Capacity Act 2005.
● There were some areas where legal frameworks needed to be further embedded. Some consent forms had not been signed by the person, but by a third party who did not have legal authority to do this.
● Applications for DoLS had been submitted for a number of people, but these had not been preceded by an assessment of the person's capacity and so it was not always clear how a decision had been made that the person lacked capacity to consent to their care and treatment including any restrictions.
● One person had an authorised DoLS in place but appeared to have capacity to make decisions about their care and support. The person told us that whilst they were not unhappy with their care, they did not want to live at the home. We have asked that the management team refer this person to an independent advocate so that their care and support arrangements can be reviewed to ensure these remain appropriate.
● There was a clear tracking system in place to monitor the dates DoLS had been authorised or needed to be reapplied for. None of the authorised DoLS included conditions.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support

● Overall people told us they received effective care, for example, one person said, "They [Staff] couldn't do anything better, the staff are brilliant". A relative told us, "The care and the attention they give to the patients is good, it feels like a happy place".

● People had access to a range of health care professionals such as tissue viability nurses, speech and language therapists, opticians and community mental health teams. Each week there was a formal GP surgery. This helped to ensure that they received timely and appropriate healthcare support.

● One healthcare professional commented positively on their effective relationship with the service, and its staff, saying, "It is very good. We used to get called in for nothing but there has been a definite improvement. Our instructions always get carried out. I don't know why it has improved but it is definite. We get very clear updates when we arrive. I would be happy to have my mum here".

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as 'Good'. At this inspection this key question has deteriorated to 'Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
● Whilst staff were seen to offer people some choices, more needed to be done to support people with expressing their views and to be involved in decision making.
● Whilst people downstairs were shown 'show plates' of each menu option to help them make their choice at lunchtime, this was not done upstairs. The show plates used were covered with a plate cover which would have made the meal difficult to see.
● The advertised menu was not what was served. We saw one person being asked what they wanted for lunch, the person had to ask what the choices were. They were told sausage roll or pasta. There was no further description offered about what type of pasta and the sausage roll was in fact pork wellington with vegetables and mash.
● On both days, lunch-time dessert was a bowl of mousse. We did not see anyone being offered an alternative.
● People taking their meals in the lounge were not offered condiments. One person ate very little of their main course, they told staff they did not like it, but they were not offered an alternative. Many of the food charts lacked evidence of people being offered an alternative when they did not eat well.
● One person was observed to stand, setting off their chair sensor alarm. A care worker responded to the alarm, the person told them they wanted to go to their room, the care worker told them, 'No sit down, it's supper time".
● None of the people who were able to comment, were aware of having a care plan and no-one had contributed to its content.
● There was some evidence that action was being taken to reinstate formal reviews with people and / or their family members, but this needed to be further embedded to be an effective tool for supporting people to express their views and be actively involved in making decisions about their care.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
● People told us that staff were kind and caring and treated them with respect. One person told us, "They [Staff] are very nice, they take the time to tell you in a way you understand… they are kind, very, very nice". Another person said, staff "Always wanted to do things for her". A third person said the staff were "Wonderful". A relative told us, "[Staff] know [Family member] really well and really care".
● The service had received a number of compliments on the helpful and caring approach of the staff team. Comments included, 'The staff can't do enough for her, they're very gentle and reassuring to her' and 'The care afforded to [Family member] was consistently respectful and attentive to her individual needs. All staff

demonstrated a helpful and caring approach'.

● We saw examples of staff communicating with people in a respectful, compassionate and friendly manner. For example, one staff member, who was not a care worker, spent time reassuring a person who was distressed and expressing a wish to go home. Ancillary staff spoke fondly about people living within the service and told us how they often spent time with them chatting.

● The permanent staff were aware of people's preferences and people's responses and body language indicated they felt comfortable in the company of staff.

● Care staff respected people's individual privacy by knocking on doors before entering their room.

● However, some of our observations indicated that staff did not always provide care and support in a person-centred manner. These have been described elsewhere in this report.

There were also missed opportunities for staff to engage with people and instead there was a focus on the completion of tasks. Care staff told us they did not have time to do this.

● Staff understood the importance of supporting people to maintain their independence and shared examples with us which demonstrated how they encouraged this in practice. For example, one staff member told us how they encouraged one person to take walks in the garden to maintain their mobility and how they supported another person to feed themselves as much as possible.

● Records relating to people's care and to staff were not stored securely. A large amount of confidential records were stored in empty rooms and in the corridor of the disused floor of the home. It was possible for visitors to the home to access this area.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection this key question was rated as 'Good'. At this inspection this key question had deteriorated to 'Requires improvement'. This meant services were not planned or delivered in ways that met people's needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Relatives told us they were welcomed at the service. This helped to ensure that people maintained relationships that were important to them. They also told us they were kept well informed about their family members care. One relative said, "I am totally kept informed, even if it's to say she is ok"
- However, people were not being provided with sufficient opportunities to take part in meaningful activities.
- There was currently a very limited programme of planned activities as the home had, for some months, been without any activities staff, or wellbeing coordinators. The activities were in the main provided by periodic external singers or entertainers on an occasional basis. Pupils from a local college visited periodically to engage with people as did pet therapy animals.
- People's individual activity records had been completed on a regular basis up until July 2019 but there was very little documented after this date. For example, one person who was cared for solely in their room had an activity and social care plan which stated they liked to have one to one session in their room. The last recorded entry of any one to one session was 22 July 2019. The monthly evaluations of this person's activity plan were regularly stating '[Person] enjoys one to one session with activity staff, but there was no evidence that these were happening, and no activity staff were in post. We saw other similar records.
- Staff told us they did not have time to provide activities alongside their other duties and they all agreed that people needed more opportunities for social stimulation. One staff member said, "Yes staff are kind, but there is not enough interaction, they could be talking to [People] more".
- People and their relatives confirmed that there had been a decline in the quality and quantity of activities. One person told us that all they did all day was sit in their chair. A relative said, "Activities could be improved…. She used to have her nails done, it doesn't happen anymore".
- The provider had already identified that this was an area where improvements were needed, and a new wellbeing coordinator had just been appointed to provide 33 hours of activities weekly. They were only in the second week of their new role and so it was too early to be able to assess the impact of this.

We were not assured that sufficient action had been taken to address the need for meaningful activities and to protect people from the risk of loneliness or social isolation. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

- Some technology was used to support the provision of responsive and timely care. For example, sensor mats were used to alert staff that people at high risk of falling were mobilising.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Whilst people looked relaxed and comfortable around staff, our observations indicated that the care was task focussed and there was limited interaction with people outside of completing care tasks. Staff told us they did not have time for this.

● Care plans contained some person-centred information about people's preferred routines and their likes and dislikes, but this was not consistent and in practice staff told us they did not always read the care plans. For example, one staff member said, "No I don't read the care plans, I have no idea what's in them, we learn about them [People] through the flash meetings or handover or ask the nurse".

● Where preferences were recorded, records did not provide assurances that these were being met. For example, there was little evidence that any of the people whose records we viewed were supported to have regular baths or showers despite this being their documented preference. In some of the examples we saw, people had gone a whole month without having a bath or a shower. Staff told us they offered people baths but this was declined.

● The handover sheet stated that people should be offered the toilet, or a pad change every four hours or sooner if requested. Records did not indicate this was consistently happening. For example, one person had been assisted with a pad change at 8.30am. The next recorded pad check was at 3.30pm when they had required a full change of bed linen due to their pad being overfull.

● Overall daily records were mostly a list of the personal care tasks that staff had completed and rarely provided any insight into person's emotional wellbeing or mood.

● Care plans contained inconsistencies about their assessed needs or expressed wishes. For example, one person's repositioning chart said they should be repositioned every 4 hours, their care plan summary said two hourly. The handover sheet gave no guidance, even though it did for other people. One person had a 'Remember together' document, which was a type of end of life care plan. This stated that they had no religious requirements in relation to their end of life care. However, their end of life care plan stated that they wanted a priest to visit them. We were concerned that due to conflicting records, this wish might not be met. A third person's care plans stated in varying places that they were both 'friendly and sociable' and later 'Not sociable' and 'Is Roman catholic and likes to worship' but later stated that they no longer practice their faith.

● To address inconsistencies in records and to ensure these were reflected people's current needs, a programme of complete review of all care plans is taking place led by the turnaround manager.

● A 'Resident of the day' system was being re-embedded so that all aspects of a person's care and support provided was reviewed and updated regularly at least once a month.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● There was some evidence that the service was meeting the AIS. People had a communication plan. This described whether the person had any sensory deficits and whether they were able to understand choices and express their views.

● The turnaround manager advised us that staff had access to a range of pictorial communication aids to support people to make decisions and choices about their care, but we did not see these in use throughout the inspection. We were advised that the service user guide was produced in an 'Easy read' format.

Improving care quality in response to complaints or concerns

● Information about how to complain was available within the reception area and in the service user guide but was not displayed anywhere within the areas of the home where people could access this, and we have asked that this be reviewed.
● People and their relatives mostly expressed confidence that they could raise any issues or concerns with any member of staff or the registered manager and that these would be addressed.
● A complaints log was kept but this did not provide complete assurances that complaints had always been responded to appropriately. There was one entry from December 2018 for which we could find no records to confirm the nature of the complaint or the way it had been responded to.

End of life care and support
● Three people were currently receiving end of life care. 'Just in case' medicines had been prescribed to ensure that their pain and comfort was managed.
● Where appropriate records included a 'Do not attempt cardio pulmonary resuscitation' (DNACPRs).
● A number of the compliments received by the service praised the quality of end of life care and spoke of staff going the extra mile to ensure people had all they needed in their final days.
● Staff described how they cared for dying people in a compassionate manner. One staff member told us, "We give hourly mouth care, reposition them every two hours and make them comfortable. We hold their hand". They told us how they cared for people's bodies following their death then dressed them in special clothes ready for their families to come and spend time with them.
● End of life care plans were in place but those seen were largely limited to a record of the persons wishes following their death, not how their care should be provided in their final days.

Requires Improvement

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as 'Good'. At this inspection this key question has deteriorated to 'Requires improvement'. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Feedback about the registered manager was generally positive. Comments from staff included, "They are a good manager", "She talks nicely, she is ok, very nice" and "[Registered manager is very good, a very nice person, she looks after the residents…. Has more patience, has contact with staff". Some staff told us they would value the registered manager spending more time out of their office and in the care giving areas. They felt this would help to ensure she was aware of the challenges they faced.
- The registered manager was supported by the provider who had a range of systems in place to ensure the smooth operation of the home. This included a clear framework for quality assurance which included a range of daily meetings, and weekly, monthly and quarterly audits for measuring the quality of the care provided.
- However, it was evident that in the six months prior to our inspection, not all these tools had been consistently used to help identify areas where quality and safety of care was being compromised and to drive improvements. The systems in place for monitoring clinical risk were not being effective and had not identified or address the concerns we have reported on in our safe domain. Some care plans had not been updated in over 12 months despite there being a clear change in their needs during this period.

A health and safety audit carried out by the provider in June 2019 had identified that actions from the fire risk assessment were still outstanding. We found that these had still not been fully addressed when we inspected in November 2019. The quality assurance framework required 12 care plan audits to be undertaken each month, but only 13 had been audited within the five months June – October 2019. This meant that the concerns we found with regards to gaps in, and the consistency of, care records had not all been identified and addressed.

- The systems in place had not been effective at ensuring that people received a service that was person centred and focussed on their individual needs.

The failure to effectively and consistently implement a governance system to ensure the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

- The provider had undertaken an internal inspection of the service on 10 October 2019 which was robust and had identified a number of concerns, including the lack of staff trained in fire evacuation drills, concerns around mattresses being set on the wrong setting, lack of staff supervision and concerns about the

completion of daily care records. They had assigned a 'Turnaround Manager' to support the registered manager drive improvements and a service improvement plan (SIP) had been developed to support this.
● However, progress with these improvements had been hampered due to the absence of the registered manager and other staffing challenges within the service, however, the service had, for example, passed its first medicines audit in three months and the overall scores on the providers own checks of quality within the service had improved from 65% three months ago to 76% currently. There was, however, more to be done and the provider acknowledged this.
● To support this, we recommend that actions to address areas of concern need to be more specific and relevant and realistic in terms of time scales. For example, one of the issues identified on the SIP was that care provision was not dignified or respectful, individual preferences were not met, care was functional and not consistent. The action planned to try and achieve improvements was 'Residents and / or their loved ones must be involved in care planning'. There was no further detail about how this was to be achieved.

Planning and promoting person-centred, high-quality care and support with openness; how the provider understands and acts on their duty of candour responsibility
● Whilst we did observe that staff were often seen to be smiling, positive and friendly in their approach to people, as mentioned elsewhere in this report, we also saw some more neutral interactions, and the approach of staff was, at times, one which was more focussed on the completion of tasks rather than spending time with people.
● The provider's brochure for the service contained a number of inaccuracies and could be misleading. For example, it stated that the home has a resident's forum, it does not. It says that the home has a specially adapted mini bus to take residents on trips to the theatre and local places of interest. This is not the case. In fact, we found little evidence to suggest that people were supported to maintain links with their local community other than when this was provided by families. We brought this to the attention of the turnaround manager and asked that this be revised.
● The provider was aware of their responsibility to act in an honest and transparent way when things went wrong and following a recent incident, an investigation had been undertaken and a letter sent to the complainant apologising for the shortcomings noted.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were some systems in place to seek people's views. A residents and relatives survey had taken place in August 2019. There had been six responses. 50% of the respondents had rated the activities as average. 40% of the respondents stated they were not aware of the services complaints procedures and 17% said that communication was poor. These areas for improvement had been added to the homes service improvement plan. The feedback had been positive in areas such as staff training and kindness. The management team were yet to feedback to people and their relatives by means of a 'You said, we did' response to issues raised in the survey.
● There was a 'Have your say' feedback station in reception where people, their relatives or professionals could share their experience. This was not accessible to people though.
● Periodic 'Relatives' meetings were held. They were updated on staffing issues and encouraged to give their feedback about the activities, trips they would like to go on and the food. The last meeting was held in May 2019 where some of the issues being raised reflected some of our findings. For example, we noted there was no reception staff and that it therefore took some time for the front door to be opened. We queried this with the turnaround manager who advised that there are no plans to appoint a receptionist. Relatives were also raising concerns about the quality of the activities. We have also identified ongoing concerns with regards to this and so are not reassured that the feedback from people is being acted upon effectively.
● Staff expressed regret at the lack of supervision but overall told us morale and teamwork was, good. There

was mixed feedback about whether the management team listened to and acted upon the views of staff. Some staff felt this was the case, however, two staff told us that they had raised concerns about the daily flash meetings being held at 11am as this clashed with their break times, which meant it was difficult to ensure there were always enough staff to supervise people. They told us this had not resulted in any changes being made which is of concern bearing in mind our findings regarding the oversight of people's safety when in the communal areas.

● Staff meetings were not being held regularly. There had been a care staff meeting in October 2019, the one before that had been in January 2019. Staff meetings are useful for sharing information with staff, monitoring the culture within the service and allowing concerns or differences to be opening discussed.

● Whilst staff told us they liked and respected the registered manager some staff told us they had not always felt valued or thanked for their contribution, particularly when picking up additional shifts. They felt their extra contribution could be better recognised.

Working in partnership with others

● Local health care professionals told us they had open and collaborative working relationships with the service.

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 | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Insufficient action had been taken to meet people's needs through the provision of meaningful activities and to protect them from the risk of loneliness or social isolation. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to people's safety had not been adequately assessed or planned for. This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There had been a failure to operate effective systems to ensure compliance with the fundamental standards and to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance. |

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

There were insufficient numbers of staff deployed at all times to meet people's needs safely. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

Staff had not received all of the required training, professional development, supervision and appraisal to enable them to carry out their role. This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing