New Century Care (Ash) Limited

High View Oast Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection visit was carried out on 21 and 22 September 2016 and was unannounced. The previous inspection was carried out in September 2015, when areas requiring improvement were noted.

High View Oast Nursing Home is a converted Oast house, and is nursing home for up to 33 people. The bedrooms are situated on both ground floor and first floor, and consist of a mixture of single and double rooms. There is a lift providing access between floors. The communal accommodation is situated on the ground floor and consists of two interlinking lounge areas, a dining room, a small quiet lounge, and a porch area. On the day of the inspection there were 22 people living at the service.

There was no registered manager in post. The service had an interim manager who had left on 16 September 2016. A new interim manager was due to start on 26 September 2016. The regional manager told us they planned to work at the service until a permanent manager had been appointed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. We were supported by the regional manager, the quality manager and deputy manager.

At our previous inspection on 21 September 2015 the service was rated as 'requires improvement'. At that time areas for improvement had been identified by the management team and action plans were in place to address the shortfalls. However, at this inspection we found the required improvements had not been made and additional shortfalls in the service were identified, as detailed in this report.

Although people told us they felt safe living at the service, people were not fully protected from harm or abuse. The management team had failed to report incidents of alleged abuse by staff to people to the local safeguarding authority, in line with safeguarding protocols.

Risk assessments to show staff how to support people positively when their behaviour were not detailed enough. There was no information on what may be the trigger to this behaviour and how to reduce the risk of this happening again. Measures were not in place to reduce the risks and keep people as safe as possible. Some risk assessments to support people with their mobility did not have sufficient information to guide staff how to move people consistently and safely.

Accidents and incidents were recorded but lacked detail, and these were not analysed so action could be taken to reduce the risk of further events.

There was not enough staff on duty to ensure people's needs were fully met. On the day of the inspection the deputy manager confirmed that staffing levels were not up to the preferred levels due to staff sickness. Recruitment procedures had not been followed to ensure staff had been recruited safely.

People were at risk of harm as they were not always receiving their prescribed medicines. The storage room for medicines was not maintained at the correct temperature to ensure the medicines were safe to use.

Checks on the equipment and the environment were carried out, but staff could not find the environmental risk assessments. The service had a 'grab file' which was available in case of an emergency such as a fire, and each person had a personal emergency evacuation plan in place. Regular fire drills had been carried out.

The training programme had not ensured that all staff had received the training and training updates they needed to carry out their roles safely.

During the last inspection in September 2015 it was noted that not all staff had received a yearly appraisal to discuss their training and development needs and the programme of staff supervision was not up to date. There was an action plan in place to address these shortfalls, but at that time of this inspection there remained staff who had not had a one to one meeting with their line manager or received an annual appraisal.

Meetings were held with the nursing staff, and care staff to encourage them to voice their opinions of the service and discuss any issues; however minutes of the senior staff meeting were not available at the time of the inspection.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. One application to deprive a person of their liberty (DoLS) had been processed through the local authority and granted. Staff did not have a clear understanding regarding DoLS as there were people living with dementia who lacked capacity, and who needed constant supervision and were unable to leave the service. No DoLs applications had been made in these cases.

People's privacy and dignity was not always upheld. At times people had to wait to be supported with their personal care until early afternoon, whilst others had to wait to be supported with their mobility.

People's care plans varied in detail and they were not always personalised. The plans contained out of date information which did not give staff clear guidance to ensure people were receiving care in line with their current needs. Monthly care plan reviews were carried out but the main care plans were not always updated with full details of people's current needs.

Staff told us that they sometimes found it hard to keep up with people's changing needs as there was only a staff handover between nurses and they did not attend. There was a ten minute meeting each day but this happened at 11am and staff thought this was too late as they needed to know if people's needs had changed before they went on the shift first thing in the morning. This situation had resulted in poor communication and there had been instances when staff were not aware of people passing away or those who required to attend hospital appointments.

There were two activities co-ordinators who encouraged and supported people to maintain their hobbies and interests. They provided group and individual activities to each person living at High View Oast. People and relatives told us they enjoyed the activities and they had really improved.

Staff greeted people as they went about their duties and people were offered choices about their daily

routines, and what they wished to eat. People were encouraged to remain independent as possible and do things for themselves.

The complaints procedure was on display to show people the process of how to complain. The process to respond to complaints had not been followed to ensure that people were responded to within the agreed timescales.

People had opportunities to provide feedback about the service provided. Quality assurance surveys were sent out annually directly from the organisation's head office. Results had been received in June 2016 but there was no evidence to confirm that people had been advised of the results or what action was needed to improve the service. At the previous inspection in September 2015 we noted that feedback from other stakeholders, staff and visiting professionals had not been gathered to ensure continuous improvement of the service, based on everyone's views. This had not changed at the time of this inspection.

There were systems in place to review the quality of all aspects of the service but these were not effective. The service had received a 'mock inspection' from a quality assurance provider in May 2016 and an action plan was put in place to improve the service. However, not all of the shortfalls identified were included in the action plan, and there remained many areas of concern which had not been addressed and improved.

Staff said they did not feel the service was well led as the management was unstable and different managers and senior staff had left the service in last few months. They told us they did not always feel they were listened to and their opinions taken into consideration.

During the previous inspection in September 2015 it was noted that records about people's end of life wishes had not always been completed, and there was a lack of people's personal life histories. At this inspection life histories had been completed and end of life records were in place however, people's records lacked accuracy and were not always updated and fully completed. Other records, such as the emergency plan, and environmental risk assessments, could not be found.

People were supported by their relatives to be involved in planning their care and to make decisions about their daily lives. People told us they enjoyed the food and they had choices. Records showed that people were assessed to make sure they received a healthy diet to ensure their nutritional needs were met. There were four weekly menus in place but no evidence to show that people had been involved in planning the menus.

People's physical and mental health was monitored and people were supported to see healthcare professionals. People and relatives told us the staff were kind and respected their privacy and dignity. Staff were familiar with people's likes and dislikes, and supported people with their daily routines.

Staff had been trained in safeguarding adults, and were aware of the service's whistle-blowing policy. They knew how to raise any concerns with the manager, or with outside agencies if required. The provider had ensured that the published rating from the previous inspection was on display.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff had not reported incidents to the local safeguarding team when people were at risk of harm. Risks were not always assessed and managed.

Accidents and incidents had been recorded but not investigated or analysed to ensure action was being taken to reduce the risks of further events.

There were not always enough staff deployed in the home to meet people's care and support needs. Staff had not been recruited safely.

People's medicines were not well managed, stored and recorded accurately. Some people had not received the medicines they needed.

Checks had been carried out on the service, but the fire alarm points had not been tested for over a week and environmental risk assessments could not be found.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The programme of supervision, including clinical supervision for nursing staff, was not up to date to ensure that staff had the opportunity to discuss their role on an individual basis with their line manager.

The training programme was not up to date and not all staff had received the training they needed to carry out their roles.

Staff had received Mental Capacity Act and Deprivation of Liberty Safeguards training but there was a lack of understanding of how this was applied to people's care.

Staff were knowledgeable about people's health needs; however, records did not always confirm that people had the support they needed to remain well.

A variety of food and drinks was provided to ensure people received a nutritious diet.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity as they had to wait for support with personal care.

People told us that staff were respectful, kind and caring. People were offered choices and were encouraged to remain as independent as they could be.

People's families and friends were able to visit at any time and were made welcome.

People's personal information was stored securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans varied in detail and were not always personalised to ensure that people received their care in a way that suited them best.

Although care plans had been reviewed regularly, the main care plans had not always been updated with people's current needs.

Formal complaints had been investigated and resolved, but they had not always been responded to within the timescales in the provider's policy.

People and relatives told us they enjoyed the activities. Group and individual activities were provided.

Is the service well-led?

Inadequate

The service was not well-led.

The management team had failed to raise safeguarding incidents to the local authority or to notify the Care Quality Commission.

Checks and audits had not identified the shortfalls found during this inspection. Staff did not feel the service was well led due to the unstable management of the service. Audits identified actions to be taken but there was no evidence that a system was

in place to check that actions had been completed by staff.

People had opportunities to provide feedback about the service they received but the information lacked analysis to help work towards continuous improvement of the service. Staff and other relevant bodies had not been included.

Records could not be found at the time of the inspection and those assessed were not always up to date or accurate.

High View Oast 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.

The inspection took place on 21 and 22 September 2016 and was unannounced. It was carried out by three inspectors.

A Provider Information Return (PIR) was submitted by the service before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications we had received. Notifications are information we receive from the service when significant events happen, like a serious injury.

We looked around all areas of the service, and talked with seven people who lived at the service. Conversations took place with people in the communal rooms and their bedrooms We observed the lunch time meals and observed how staff spoke with and interacted with people.

We spoke with seven people, four relatives, two nurses, ten staff, the cook, the regional manager, the quality support manager and deputy manager. We also made observations throughout the inspection.

We contacted two health care professionals but feedback had not been received at the time of writing this report.

The previous inspection was carried out in September 2015, when the management team had identified shortfalls in the service and had action plans had been implemented to improve the service.

Inadequate

Is the service safe?

Our findings

People said they felt safe living at the service. They told us, "Yes, I do feel safe here". "I share my room and I feel safe here". "The staff make sure I am OK". One relative said, "I go home and feel my relative is safe living at High View Oast".

Although people told us that they felt safe, people were at risk from the unsafe management of medicines. In some cases there were specific procedures and protocols such as two staff to witness and sign records when giving people certain medicines. Nurses were not following current guidance to administer these medicines safely. Two people's medicine was dispensed at the same time, into two separate pots and taken out of the medicine room to give them to the people. There was a risk that the two pots could become mixed up by dispensing and administering the medicines at the same time. One nurse gave a person their medicine in their bedroom whilst the other nurse stood outside of the room and did not see the medicine being administered but had signed to confirm they had.

Each person's medicine should be dispensed separately to ensure it is given to the right person at the right time. This reduces the risk of people receiving the wrong medicines. After giving people their medicine the nurse went back to the medicines room where we noted that the register had already been signed by two nurses to confirm the medicine had been given. All medicines should be signed after being given and not before the person has taken their medicine to avoid people being given too much medicine.

The medicine stock cupboard was over stocked. The service was in the third week of a four week medicine cycle and had eleven days left of the cycle. One person required ten Hyoscine patches per cycle and there were 22 in stock. If the right amount of medicine had been ordered and administered no patches should be remaining at the end of the cycle. Another person's medicine left for the remaining cycle should have been 1,000mls of Phenytoin for the control of seizures, there was 2,000mls in stock. The overstock of medicines indicated that these people may not have received their medicines as prescribed.

There were out of date needles and bottles dating back to 2014 in the medicines room and indicator strips that had expired in 2015 available for use by nurses. Surplus, unwanted or expired medicines should not be stored. There was a risk that they could get mixed up and be accidentally given to other people and may cause harm.

One person's medicine had been stopped by their doctor the stock remained in the blister pack in the rack and had not been removed; there was a risk that this medicine might still be given to them.

Liquids and tablets were being stored together in the medicines cupboard which was not in line with current guidance. The identity cards which separated people's medicine records in the Medicine Administration Records (MAR) folders were loose and fell out. There was a risk that they could be misplaced or be lost. Bottles of medicines were not always dated when they were opened so staff were not aware of when they should be used by.

Medicines were not stored at the correct temperature to ensure the effectiveness and quality of the medicines. The temperature in the medicine storage room was over 25 degrees (the temperature recommended by the Royal Pharmaceutical Society of Great Britain), on 14 occasions since 19 July 2016. The temperatures had been recorded but no action had been taken to reduce the temperatures. There was a risk that high temperatures would reduce the effectiveness and safety of people's medicines. The nurses said they had told management and maintenance about the room temperature, but no action had been taken.

People were not receiving their medicines consistently. One person went out for the day and their medicines were not administered. The medicine administration record (MAR) dated 14/09/2016 had been completed to show that the person had social leave and the medicines remained in the blister pack. The person did not receive their prescribed eight medicines. There was no evidence to show that the nurses on duty had questioned why this had happened, how this decision had been made or if medical advice had been sought for further advice.

A 'mock inspection' audit carried out in May 2016 highlighted that arrangements for repeat prescriptions were not robust. No action had been taken to improve the arrangements for obtaining repeat prescriptions. Records showed that one person had been prescribed Lansoprazole 30mgs once a day. There should have been eleven tablets left for the remainder of the cycle but there were fourteen in stock, indicating that the person had not received their medicine on three occasions.

Another person was prescribed Anastrozole 1mg tables once a day and there were eight left in the box with eleven days to go in the cycle, there was no other stock in the cupboard and the records showed that none had been ordered for that cycle, therefore the medicine was going to run out before the end of the cycle. This had not been identified and acted on.

Another person had not received their Ferrous Fumarate, 210gms for the first four days of the cycle as there was no further stock of Ferrous Fumarate 210gms in place.

Staff were failing to complete body maps and cream charts to confirm people had their topical medicines applied in line with the prescriber's instructions. One person's cream chart had only been completed 13 times in the last 45 days, showing they had not received their prescribed cream on 32 occasions.

The provider had not ensured that medicines were managed safely. People were not receiving their medicines safely and in line with the prescriber's instructions. Medicines were not being monitored to ensure they were stored at the correct temperatures to ensure they were safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people told us they felt safe living at the service, they were not fully protected from abuse as policies and procedures had not been consistently followed. Concerns about people's safety had not been reported to the relevant outside agencies, such as the local authority safeguarding team. There had been reports from staff alleging verbal abuse by other staff to people. Senior staff had started to take action with regard to the concerns but had not reported the allegations to the local council safeguarding team who would have discussed the issue and then made a decision on how to proceed. There was also another safeguarding incident when one person with complex medical conditions had not been given their medicine for one day. No action had been taken to inform the local safeguarding team.

The provider had failed to ensure that people were protected from abuse as appropriate referrals to the local safeguarding authority had not been made in line with safeguarding protocols. This was a breach of

Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulation 2014.

Staff had been trained in safeguarding adults, and were aware of the service's whistle-blowing policy. They knew how to raise any concerns with the manager and nurses and were aware that the local safeguarding team were responsible for investigating allegations of abuse.

When people needed support with their behaviour, detailed guidance was not available in their risk assessments to guide staff how to manage the risks and keep people as safe as possible. There were no further details to guide staff on what action to take if this did not work, for example if the relative did not answer the telephone or if the incident occurred at night, and if the person needed further support.

Another person who was living with dementia, liked to walk around the service, their risk assessment instructed staff to 'closely supervise them'. There were no instructions on how this was to be achieved and how to support the person to remain safe while walking around. One incident report stated that a person hit a member of staff twice and the staff member told the person this was 'unacceptable behaviour'. The person was living with dementia and may not understand this response. There were no details in the risk assessments to guide staff how or what may trigger the person's behaviour or how they could positively support them to reduce their anxiety. The information written on the incident report indicated there was a lack of understanding by staff on how to manage problem behaviour.

The information provided to staff to support service users living with diabetes varied. In some care plans there were comprehensive guidelines. However, one person's care plan did not have details about the levels of high or low blood sugar, the symptoms to be aware of, and what to do about high or low levels. There was a high use of agency staff and the lack of clear information may put people at risk of not receiving the care they needed.

One person was living with epilepsy, had a history of seizures and was prescribed medication to control the seizures. Guidance had not been provided to staff of what care and support they required should they have a seizure. Risks to the person had not been identified and information was not available to staff about what the person's seizures looked like and when to call for emergency assistance.

There was a risk that people would not be moved safely. Consistent guidance had not been provided to staff in people's moving and handling risk assessments about how to move them safely. In some risk assessments details included the hoist required, the size of sling, and the colour strap to use and how to place the sling under the person's legs. Other risk assessments did not contain detailed guidance on how to move people safely. For example, one risk assessment said to use three care staff, one to use the hoist, one to hold the person's hands and one to explain everything to the person and to perform the manoeuvre in as short a time as possible, but it did not explain exactly what the manoeuvre was and how to do it safely. Accidents and incidents had not been clearly recorded as there were no records available from March to September 2016.

The provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people, supporting people with their behaviour and health care needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us there were not always enough staff on duty and there were times when people had to wait for staff to respond to their calls. People said that on the whole staff came quite quickly but there were times when they had to wait for staff to help them to the toilet and help them to move.

Staffing levels were not sufficient to ensure people's needs were fully met. The deputy manager used a dependency tool to determine the number of staff required to meet people's needs. Each person's dependency was scored and the result added together to establish the number of staff required to meet their needs. This information was reviewed by the manager and regional manager weekly. The regional manager explained that the staffing levels were based on the occupancy level with medium dependency and then altered according to changes in the calculated dependency levels.

The deputy manager confirmed that the current staffing levels should be two registered nurses during the day and one at night and five care staff day and night. On the first day of the inspection there were four care staff on duty in the morning and three in the afternoon. This included a new staff member who should have been supernumerary, but was part of the staffing rota. On the afternoon of the first day of the inspection, the deputy manager supported people with their personal care as there were not enough staff on duty to meet everyone's needs. The deputy manager was acting as the manager of the service whilst they were waiting for a new manager to start. Directly supporting people reduced the time the deputy manager had to effectively carry out management tasks.

Agency staff were used on a daily basis to cover shortfalls in staffing but there were times when there was no agency staff cover available. The deputy manager told us that they endeavoured to use the same agency staff but this was not always possible. We noted on the rota of the week commencing the 12 September a total of eleven different agency staff were used to cover fourteen shifts.

One person told us that the agency staff did not know them as well as the permanent staff and they did not like this very much. They said that agency staff were used quite regularly. One person said "Staff are pushed but they still manage and keep smiling". A relative said "Without a doubt there is not enough staff on duty". "Sometimes staff tell my relative that they are too busy".

On the day of inspection a member of nursing staff came into the office and asked whether a member of staff was allowed to work on shift that afternoon as they were new and had been supernumerary the day before. The deputy manager called head office for advice who advised the staff member could not work unsupervised that afternoon. Although efforts were made to cover with agency staff there was no one available. We observed this new member of staff working as part of the staff team assisting experienced staff to move people as there was not enough qualified permanent staff on duty.

People had to wait to be supported with their personal care and on the second day of the inspection staff were still supporting to wash and dress in the afternoon. One person was asked by staff to wait to be supported to move from their wheel chair to a comfortable chair in the lounge after lunch. Over an hour later the person remained in their wheelchair until we reminded staff they had asked to be moved just after lunch. People accepted they had to wait and they told us staff were 'very busy' and 'sometimes there was not enough of them'.

Staff consistently told us they were there was not enough staff on duty. They said, "There is definitely not enough staff, we are so busy every day, people have really high needs here". "There is not enough staff on duty; we have so many double handers, if two people want to go to the bathroom at the same time that only leaves on member of staff to respond to everyone else". "Sometimes the nurse will help us other times they don't". They said that sometimes they were short staffed with two staff on the first floor and two staff on the ground floor and they rushed all day to make sure people had the care they needed.

The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

Staff had not been recruited safely in line with the provider's recruitment policy. Unsatisfactory references had been provided for one new member of staff. Further information had not been sought to ensure that this person was suitable to work in the service. Another file did not have a reference from the person's previous employer and no record to say why this had been acceptable and the staff member had been employed.

Four out of five recruitment files reviewed showed that full employment histories had been requested and satisfactory explanations of any gaps had been documented. However, there were gaps in one staff member's employment history which had not been explored. One nurse had left the service and then returned to a permanent position in July 2016. Recruitment checks, such as obtaining an up to date police check and checking their nursing registration was up to date had not been completed. Disclosure and Barring Service (DBS) criminal records checks had been completed for all staff before they began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

The deputy manager had checked that registrations were valid with the appropriate professional body for half the nurses. A system for checking the registration with professional bodies was not in operation. This shortfall had been identified in an audit of personnel files in May 2016 however, this had not been addressed. The regional manager said that they had not been able to obtain pin checks on the four nurses as their names had changed so they had requested the nurses provide proof of their current registration. There was no evidence to confirm that this had happened.

We recommend that the provider reviews practice to ensure that their recruitment and selection procedures are followed to ensure staff were recruited safely.

Emergency plans were in place in the event of an emergency such as fire and each person had an individual personal emergency evacuation plan (PEEP) to ensure that they could be safely evacuated from the service. Fire drills were carried our regularly but only first names of staff taking part were recorded and the deputy manager was not aware if any night staff had been taken part.

There were records to show that equipment and the premises were checked and servicing was carried out, including checks of the hoists, boilers, electrical system, nurse call system and temperature of the water. The deputy manager told us that environmental risk assessments were in place, however these could not be found at the time of the inspection. There was an unpleasant odour at the back of the premises and upstairs. We discussed this with the deputy manager who told us the flooring was due to be replaced to eliminate the odours.

Requires Improvement

Is the service effective?

Our findings

People and their relatives were satisfied with the care being provided. They said that the staff looked after them well and they enjoyed the food.

Staff told us that they received regular training, including face to face and on line (e learning). There was an ongoing training programme. including some specialist training to meet people's needs, including dementia awareness.

There was an ongoing training programme in place for staff, however staff had not completed all the training required to ensure they had the skills and competencies to perform their roles. Most staff training was by e-learning with the exception of fire safety, first aid and moving and handling training. At the previous inspection in September 2015 the deputy manager had recognised that there were shortfalls in the training programme and planned to support all staff to complete the training programme by October 2015. This had not been achieved and there continued to be shortfalls, for example, only half of the staff team had completed first aid training and less than half of the staff had completed safe moving and handling training.

At the previous inspection in September 2015 the deputy manager had recognised that the staff supervision/appraisal programme was not up to date and a new system was being implemented. However, there were still shortfalls in the supervision programme. Some staff said that they had supervision and an appraisal with the interim manager whilst others said they had not had supervision for a long time. Nurses told us that they had not received clinical supervision.

Staff told us that they did not always feel they received enough support from the provider. Staff in leadership roles told us that they did not have any guidance or training to support them to supervise staff. The regional manager recognised that there was a shortfall and told us that the new interim manager would be addressing this issue.

Staff told us that communication was poor as the staff handovers at the beginning of each shift were for nurses only. Staff gave examples of the impact of this, one staff member said that they had prepared a breakfast for a person only to find that they had passed away the previous day, another staff member said that they had attended an outpatient appointment with a person and only knew about their medicines as they had overheard the nurse talking about an antibiotic. The regional manager told us that they had introduced 10 minute meetings at 10 am each day when a member of care staff attended with the nurses to discuss any changes. Staff told us this was too late as they needed to know when they came on shift. The regional manager told us that this would be reviewed.

The provider had not ensured that staff were supported, trained and supervised to enable them to perform their role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed an induction on their first day working at the service. This included going through

emergency procedures, orientating themselves with the home, people's records and routines within the home. Staff also completed on line training based on the care certificate principles. The care certificate is an identified set of standards that social care workers work through based on their competency.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff had received training about the MCA and were aware that one person had been deprived of their liberty and how to support them when they became anxious. However, guidance had not been provided to staff in the person's care plan to ensure that the support offered by all staff was consistent. For example, if the person became anxious staff were to phone their relative so they could talk to the person and clam them down. There was no guidance about what to do if was the middle of the night or if the relative was unavailable.

People's capacity to consent to care and support had not always been assessed and the assessments that had been completed were not in line with current practice. In one person's care plan there were contradictions about their mental capacity and ability to make decisions. They needed to attend hospital for a procedure and the hospital had written to the service expressing concern about the person's consent. There was no evidence that any planning had been done to assess their capacity or whether a best interest meeting would be required to support the person to make the right decision. Another person had been seen by a psychiatrist, who diagnosed dementia, but felt they would not benefit from medicines; there was no MCA assessment completed to ensure that the person was being supported appropriately.

Staff and the deputy manager did not have a clear understanding regarding DoLS. One person had a DoLS in place and the deputy manager told us this had been applied for because the person had indicated they wanted to leave the service and were unable to. All people who lack the capacity to make decisions about their care and who need continuous supervision and lack the option to leave their care setting and are deprived of their liberty. There were people living with dementia, who lacked capacity and were unable to leave High View Oast and no DoLS applications had been made.

The provider had failed to apply for authorisations to deprive people of their liberty in line with the Mental Capacity Act. This was a breach of Regulation 11 of the Health and Social Care Act 2008.

People's health care needs were monitored. People and relatives told us that the staff contacted health care professionals when required, such as doctors and specialist nurses. The Home Enteral Nutrition (Hen) monitored people who needed specialist assistance to eat. People had regular appointments with chiropodists, dentists and opticians.

When people lost weight dieticians were contacted for support to ensure people received the help they needed. If people had swallowing difficulties they were seen by speech and language therapists. A visiting health care professional said, "Staff were very helpful and followed the dietary advice given to them". They

said they had received good feedback about the food people were offered.

People and relatives told us the food was good. They said, "The food is varied and there is always two choices". "The staff always check that my relative has had enough to eat and drink". Some people were on pureed diets in line with their medical needs and the meals were puréed in separate sections to look more appetising. We observed people enjoying their meals in the dining room, while others choose to eat in their rooms. Staff ensured that people had a choice of drink with their meal and throughout the day.

Each person had a dietary profile which contained details of their needs when eating, such as if they needed their food to be cut up, their likes, dislikes and any allergies. There was also information about their medical needs such as if they needed a diabetic diet or soft food. The chef was aware of people's likes and dislikes, which were recorded in the kitchen for them to refer to. They told us how they ensured that meals were in line with people's needs, such as adding additional creams and full fat milk if they needed extra calories to gain weight and remain healthy. There were four weekly menus in place but people were not all involved in planning the menu. This was an area for improvement.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always maintained. There were occasions when people had to wait to be supported with their mobility or to get up, washed and dressed. People and relatives said that they had to wait on occasions as staff 'were busy' but always' tried their best to make sure they had everything they needed'. Staff told us that sometimes people had to wait as there was not enough staff to respond to their needs straight away.

People's relatives said: "There seems to be more agency staff which is a little upsetting for my relative". "Sometimes I think there could be a quicker response from staff". "Staff are kind and caring, my relative is very happy here". "The staff are very kind and good, but there is not always enough of them" and "The staff are excellent".

Staff supported people at the end of their life. Some people had an advanced care plan or end of life care plan. Advanced care planning provides people and their relatives with an opportunity to talk openly and make their last wishes known. Some people had made advanced decisions, such as 'do not attempt to resuscitation' orders, to ensure their last wishes were recorded and end of life plans were in place. End of life care plans were not always completed to ensure that people's last wishes were fully recorded and would be carried out.

People's care plans and associated risk assessments were not always detailed and up to date but were stored securely in a locked office to protect confidentiality.

People told us the staff were kind and caring. They said, "The staff are like family, caring and kind". "This is a first class service, the staff look after me well". "I am very satisfied with the service". A recent thank you letter was sent to the service, stating, "Thank all of you for taking care of my relative so well. Nothing was ever too much bother".

Staff said, "I think the care staff are brilliant, I would definitely consider a family member living here". "Despite all of the changes I really enjoy working here; we really care about the people living here and are a good staff team". "We work as a team, sometimes people are taken away from their domestic duties to support people with their care or to go in the kitchen, and the staff had previous experience caring so we all work together". "We have the people's best interest at heart". "We pull together as a team and make sure people live in a happy atmosphere".

People and relatives said that they were treated with dignity and respect. Staff respected people's privacy by knocking on their bedroom doors and waiting till people responded to enter. One relative said, "The staff are respectful, they make sure my relative receives their care with privacy and dignity. They close doors and curtains to maintain their privacy when they help them to get dressed".

Staff encouraged and supported people in a kind and sensitive way. They asked what people wanted as they went about their duties. They reassured people and guided them to where they wanted to sit. Staff routinely

gave people a choice such as, 'Would you like blackcurrant or orange juice". "Would you like the window closed if it is too cold".

People had detailed life histories in their care plans so that staff were able to chat with them about their previous pastimes, family life and relatives. People were called by their preferred name and asked if they wanted to be supported by a male or female member of staff. People told us that they got up and went to bed when they wanted, and stayed in their room if they preferred their own personal space.

People's independence was encouraged. People were supported to do as much as they could for themselves, such as washing their face and dressing. People's preferred routines were listed in their care plans such as what toiletries they preferred to use.

One person told us how they liked to have their door open at all times and this was recorded in their care plan so that staff were aware. If the door was closed this caused the person anxiety and records showed that when the fire alarm went off, staff were to ensure that they opened this person's door first to reduce the risk of them getting upset.

People were being supported with their religious beliefs. There were regular visits from the local church groups and people received Communion in their rooms if they wished. Visitors were welcome in the service at all times and could see their relatives in private or in the communal lounges.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us how they had been involved in planning their relative's care. One relative explained that an assessment had been carried before their relative was admitted to the service. They also visited the service and had a look round to see if the premises was suitable. Some people had signed to confirm they agreed with their care and other care plans were signed by relatives.

There were pre admission assessments detailing people's individual needs, preferences and social needs . Relatives told us that they had been involved in the process. This ensured that people would have an understanding of what to expect from the service and to plan how their care needs would be met. This information was used as part of the care planning process.

Each person had a care plan in place. The registered nurses were responsible for making sure people's care plans were accurate, reviewed and kept up to date. Care plans varied in detail, were not well organised and were not all up to date. There were areas in the plans which did not give staff the guidance required to ensure that people received consistent, safe care.

Two people were being supported to eat through a PEG feed. (A 'PEG' is a Percutaneous endoscopic gastrostomy which is a feeding tube is inserted directly into the person's stomach). Care plans did not have detailed guidance for the care of the tube, including when it was due to be changed and the signs to look for if there was an infection present.

One person's breathing plan stated that they were 'nil by mouth', as they were fed through a PEG, and may eat and drink as they walked around the building, as they may forget. An assessment of the risk to the person had not been completed and guidance had not been provided to staff about how to support the person should this happen or how to distract the person from food and drinks. The only instruction was to rinse their mouth out. There was a risk that staff would not know what action to take is the person ate or drank something.

Some people had developed pressure areas and their skin needed to be monitored. Equipment, such as special cushions or mattresses were in place. The mattresses were used for people assessed at high risk of damage to their skin, to reduce the pressure on their skin. There was no record of the setting to be used for each person, which would vary depending on their weight and whether they were nursed sitting up or lying down. The forms in place to check the settings daily to make sure they were correct, or had not been accidentally reset, had not been completed. Some people, who were in bed, needed to be re positioned regularly to reduce pressure areas. Positioning charts were not always completed with details if people had been moved in line with the recommended timings to keep their skin as healthy as possible.

Care plans were reviewed monthly but the changes to people's care needs had not been recorded on the main care plans. Some care plans contained historical information, which was out of date and had no relevance to the care now being provided. One person's continence care plan had not been updated since 2011 and said the person used a catheter. The person no longer had a catheter in place. Another plan stated

that a person was given food by a machine and had a catheter but this was not the case as the person no longer had a catheter and they were now supported to eat by a different method.

It was noted on the provider's action plan that care files were out of date and needing reviewing. A care file audit had been undertaken and 'resident of the day' to be implemented. The resident of the day was a monthly review of the person's care completed with the person discussing any changing in their needs. The completion date was recorded as 8 August 2016. Although this process had been completed it had not identified the shortfalls we found in people's care plans.

The provider had not ensured that care plans were person centred and reviewed appropriately to ensure people's needs were fully met. This was a breach of Regulation 9 of the Health and Social Care Act 2008.

A new system of care notes had been introduced. People's daily care notes were now kept in their bedroom so staff could assess them easily. The notes included a personal care profile, observation records (cream charts, body maps), fluid charts, food and weight charts, diabetic monitoring forms, activities and daily records. Staff told us that this was working well and they found this information really useful.

The provider's complaints procedure was on display in the entrance hall and a suggestion box was available to give people the opportunity to raise any issues they had. People and relatives spoken with said they did not have any concerns or complaints. They were confident to speak with staff or the nurses if they had any issues.

The deputy manager and the regional manager were not able to locate all of the complaints records. The records they found were incomplete and did not show that a full investigation had been completed or recorded the outcome of the complaint. One complaint had been partially investigated and was still under investigation. Although records indicated that the manager had spoken with the local safeguarding team there was no further evidence of a referral or what outcome had been agreed. The complaint remained outstanding. Another relative made a complaint in August 2016. This was the second time they had complained about the care their relative was receiving. They had received an initial response advising that the manager would respond within 21 days. No response had been sent. The regional manager confirmed after the inspection that a manager had started the investigation and was going to meet with the complainant but no further contact had been made. Records also showed there had been a further complaint about a member of staff, but the complaint was not on file.

Relatives told us that the activity organisers worked really hard to make sure people enjoyed their day. They said the activities had improved and there was much more for people to do. There were two activity members of staff who provided group and one to one activities. Monthly newsletters kept people up to date with activities and forthcoming events such as pet therapy and library events including a poetry and prose afternoon. The activity staff supported group activities including talking about the current events, such as the harvest festival and autumn. They visited people in their own rooms to ensure people did not feel socially isolated. They encouraged people to participate in their preferred hobbies including knitting. They had recently held their own triathlon as their own version of the Olympic games when they presented meals and prizes.

The last resident/relative meeting was held in June 2016. Minutes showed that activities had been discussed and people had made suggestions about new activities, including crafts, bingo sessions and reading. A bring and buy sale had been help shortly before our inspection to raise funds for future events.

Inadequate

Is the service well-led?

Our findings

People and relatives spoken with said they were satisfied with the service. A relative said, "I am happy to visit, as a care home I think it is a really good service". Relatives told us that they knew who the deputy manager was and if they had any issues they would discuss their concerns with the nurses. Relatives told us that they knew that the management had been unstable and some of the care staff and nurses had left, which had resulted in different managers and the use of agency staff.

The management of the service had been unstable for some time. The previous registered manager left the service in April 2016 together with the administrator. The previous deputy manager and some nurses had also left. Since then an interim manager (from another location within the organisation) had been appointed together with a new deputy manager. During this time the regional manager had also been overseeing the service and supporting the staff. The regional manager told us that the organisation was in the process of recruiting a manager for the service. In the meantime the first interim manager had left the service shortly before the inspection and a new interim manager was due to start work in the service the week after the inspection.

Staff told us that the management team changes did not make them feel valued or supported. They said that staffing levels were consistently low, recruitment was slow and the use of agency staff put more pressure on them at times. They said that morale was 'not too good' but it was improving. They talked about the daily ten minute meetings and how the manager had completed some team building exercises which had been beneficial to staff. A staff member said, "We lost lots of good staff because the service has been unsettled but it is a lot calmer now".

Staff told us that they had worked through the changes in the service and were passionate about putting people first and proving personalised care but this was being compromised by a lack of staff. They said they had good feedback from people and had a good rapport with them and their families. They said, "We give people choice, and treat them how we would treat our parents". "We are respectful, treat people with dignity and ensure they have the care they need"
At the last staff meeting in August 2016 staff had discussed the culture of the service and the importance of team work. There had been team building sessions to support staff in this area. It was acknowledged that there had been a lack of management in the past.

Following the previous inspection in September 2015 the provider sent us an action plan to address the identified shortfalls, including the lack of analysis of accidents and incidents, the lack of clinical supervision and appraisal for nurses and staff. It had also been identified that records were not accurate or being completed appropriately. We reviewed the action plan and found that you had failed to ensure the identified actions had been carried out to improve the service.
The action plan recorded that accident/incidents analysis was not undertaken consistently or effectively. The action to be taken was 'analysis and trending to be undertaken for the last three months and tends identified to be actioned and shared with staff.' There was no responsible person named, no progress to date and the due date was 30 August 2016.

The recording of accidents and incidents was not detailed and records were not in good order to track that appropriate action had been taken. The information was in two different files, which the deputy manager could not initially find. The last accident form in one folder was dated March 2016 and no further events had been recorded on this file. However, in another folder. Two incidents were recorded in September 2016. There were no records of any accidents/incidents which may have occurred in April, May, June, July and August 2016. There was no analysis by the manager to show that any patterns or trends so action could be taken to reduce the risk of accidents happening again.

There were regular checks and audits in place but these had not been effective to make sure that issues were picked up and action was taken to address shortfalls and continually improve the service. A 'mock inspection' had been completed in May 2016 to identify areas where improvements were required to comply with the regulations. This had identified some of the shortfalls we found during our inspection but not all. The identified shortfalls such as ensuring service users had enough medicine for the cycle, recommendations to ensure capacity assessments were carried out in line with the Mental Capacity Act 2005 and to ensure care plans had accurate up to date information had not been actioned and remained outstanding.

The regional manager said that as a result of the audits, improvements had been by introducing other management tools such as 'the resident of the day', daily walk around and the daily ten minute meetings.

The regional manager visited the service on a monthly basis to assess the quality of care being provided. The last visit by the regional manager was 21 September 2016. The review did not identify all of the shortfalls we found. Complaints had not all been recorded, fully investigated and responded to and this had not been picked up by the audits.

The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely, however, these were not consistently followed by staff. For example, staff had not followed your medicines policy and made sure service users had sufficient medicines in stock or were given their medicines safely. When allegations of verbal abuse and reports of service users not receiving their medicines had occurred, the manager had failed to report this to the local safeguarding team in line with safeguarding protocols. The recruitment policy for new staff had not been followed and complaints were not accurately recorded, fully investigated and responded to within the recommended timescales.

The deputy manager told us that nursing staff were using a new office and records were in the process of being moved. Throughout the inspection staff struggled to find records, some were eventually found but others such as environmental risk assessments could not be found. After the inspection the regional manager sent us a copy of the staff meeting minutes. Records were not always in good order, lacked clarity and were not easy to follow.

Accurate and complete records in respect of each person were not maintained. For example, one person had a pressure area and records showed that nurses had dressed the wound 15/06/2016 but there were no further information recorded until 12/09/2016 when it was recorded that the area had healed. Another area was dressed on 15/06/2016, 06/08/2016, and 12/09/2016. Records had not been completed to show this had been reviewed. The podiatrist had been contacted but the information was difficult to find, the records did not show that staff had followed the podiatrist's instructions. Information in care plans had not been archived and there were information relating to service user's care as far back as 2011 making the care plans large and difficult to use.

The service had sent a quality survey to people in May 2016. One person had commented, "The staff get

behind and I have to wait a long time to be washed in the morning. When they do arrive I feel that they are rushing" and "Have more staff in the mornings, I don't want to be washed while they are dishing up lunch". Another person had commented, 'Often when I ask for something I'm told 'you'll have to wait". Action had not been taken to improve this and at the time of the inspection people still had to wait, sometimes until the afternoon to get washed and dressed.

At the previous inspection in September 2015 it was noted that although feedback had been received from people, the provider had not actively encouraged feedback about the quality of care from a wide range of stakeholders, such as staff, visiting professionals and professional bodies to ensure continuous improvement of the service.

The registered provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services. They had failed to seek and act on feedback from relevant people, on the service provided to continually evaluate and improve the service. Records could not be found, were not clear and completed accurately. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a development programme for managers and clinical lead roles had attended conferences to keep their practice updated. There were also meetings for managers from other locations to discuss current practice. The manager was in the process of contacting 'My Home Life' which promotes quality of life and delivers positive change in care homes for older people.

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, so we can check that appropriate action has been taken. This includes when safeguarding alerts were made to the local authority. The provider had not notified CQC about the allegations of abuse.

The provider had displayed the CQC rating from the last inspection in July 2015 on their website. A copy of the report summary was displayed in the entrance hall.

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 meeting the needs of people to ensure their health care needs were met.

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 failed to apply for authorisations to deprive people of their liberty in line with the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that people were protected from abuse as appropriate referrals to the local safeguarding authority had not been processed in line with safeguarding protocols.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people, supporting people with their behaviour and health care needs. The provider had not ensured that medicines were managed safely. People were not receiving their medicines safely and in line with the prescriber's instructions. Medicines were not being monitored to ensure they were stored at the correct temperatures to ensure they were safe.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services. They had failed to seek and act on feedback from relevant people, on the service provided to continually evaluate and improve the service. Records could not be found, were not clear and completed accurately.

The enforcement action we took:

Warning Notice