Four Seasons Homes No.4 Limited

Kingfisher House Care Home

Inspection report

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Date of inspection visit: 05 August 2015
Date of publication: 10/11/2015

Ratings

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

Overall summary

The inspection was unannounced. We last inspected this service on the 21 and 29 October 2014. At this inspection we identified two areas which required improvement. We found there were not always enough staff to meet people's needs in a timely way and made a compliance action. Whilst recognising that the service were trying to recruit new staff the impact of not having enough staff affected people's experiences. We also identified concerns around how the service responded to people's needs and how care records did not always help staff deliver effective care.

The service can accommodate up to 91 people and can provide both residential, and, or nursing care. It has specific units for people living with dementia. There is a registered manager in post.

'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

Summary of findings

During this inspection we identified concerns with staffing levels and the use of temporary staff to deliver care which resulted in a higher level of dissatisfaction with the service and less cohesion amongst the staff team. We were given several examples of where staff did not adequately respond to people's changing needs because they were not familiar with them. We also found care records were very complex which made it difficult to see at a glance what people's main needs were. Staff who were most familiar with people's needs reported that they were being asked to work in other areas of the home and some were leaving after many years of service.

We identified concerns around the safe administration of medicines. This was of a particular concern because we have identified concerns with medicines at previous inspections in 2014. In September 2014 we served a warning notice on medicines because the provider had not improved their practice from an earlier inspection in June 2015, when we had made a compliance action. When we inspected the service in October 2014 improvements in medicine practices had been made but unfortunately these had not been sustained.

Staff induction was good and most staff said they were supported for their job role but we identified gaps in staff knowledge which meant they were not always able to give care safely.

Staff were not knowledgeable about how to support people who lacked the capacity to make complex decisions about their health and welfare. There was poor understanding of advocacy and people were reliant on care staff.

There was poor monitoring of people's weights to ensure they were adequately nourished and people reported unfavourably about the food.

Staff were not always responsive to changes in people's health care and people's needs were documented but records did not reflect people's choices and preferences in care.

People social needs were not adequately met and some people were frustrated about the lack of opportunity to get out.

Staff were mostly caring but some people were anxious about the loss of regular staff and the continuity of care. They reported favourably about the care staff but had less confidence in agency staff.

People said they had opportunities to raise concerns and give feedback about the service they received but were not sure if their concerns were effectively addressed.

We had concerns about the management of the service due to what people were experiencing and the inconsistencies we identified around the home. Some people felt it was a good service whilst others were disengaged and largely unoccupied throughout the day. We have received a number of concerns about how people were supported in terms of their health and welfare. The home were proactive in addressing these concerns but were not identifying them for themselves which made us conclude that their quality assurance systems were not adequately robust and improvements were not sustained.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

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

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

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

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under

Summary of findings

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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

People were not safe.

There were not always enough staff with the necessary skills and experience to meet people's assessed needs and there was ineffective monitoring of staff.

People did not always receive their medicines correctly and as intended.

Risks to people's safety were not always adequately met.

Staff had enough knowledge of how to protect people in their care and raise concerns if need be.

Is the service effective?

Inadequate

The service was not always effective.

Staff received training and support for their roles but this was not always effective and there were gaps in staff's knowledge.

People lacking capacity were supported with decision making but we could not always be assured this was done lawfully because staff did not have enough knowledge.

People were not always adequately supported to eat and drink in sufficient quantities for their needs and the risks of malnutrition were not effectively monitored.

People's health care needs were not always met.

Is the service caring?

Requires improvement

The service was not always caring.

People felt well cared for by regular staff, not all were comfortable with agency staff.

People's independence and dignity was promoted but the availability and visibility of staff meant people did not always get support in a timely way which could compromise people's dignity.

Is the service responsive?

Requires improvement

The service was not responsive to people's individual needs.

The range and frequency of social activities were poor and did not meet people's social needs.

Care plans were difficult to follow and would not help staff unfamiliar with people's needs provide effective care in line with people's wishes.

Summary of findings

Is the service well-led?

Some staff felt unsupported and people said they did not always experience a service which was responsive to their needs.

There were systems in place to get feedback from people, staff and relatives but we could not always see how these had been acted upon to improve the service.

Some improvements were being introduced but due to instability in staffing morale was low and we had concerns about recent safeguarding and how the home were not always meeting people's care and welfare.

Requires improvement

Kingfisher House Care 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 5 August 2015 and we have since requested some additional information. The inspection was carried out by three inspectors, and a pharmacy inspector. We also had an expert-by-experience who is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience in supporting older people.

As part of this inspection we reviewed the information we already held about the service which included notifications. A notification is information about important events which the service is required to send to us by law. We looked at previous inspection reports and information received from share your experience which is another way people can tell us about their experiences. We have also received a number of concerns and safeguarding notifications which have been referred to the Local Authority, some of these are still under investigation and we have asked the manager for an update.

As part of our inspection we carried out a medicines audit on two of the units. We carried out direct observations of care practices on three units and visited people using the service and staff on the four units. Our observations included activities being provided and lunch. We spoke with twenty people using the service, five relatives and twelve staff, including agency staff, permanent staff and senior staff. We looked at five care plans. We spoke with other professionals involved in supporting people using the service as part of this inspection. We also looked at records relating to the running and management of the business.

Inadequate

Is the service safe?

Our findings

At our last inspection on the 21 and 29 October 2015. We identified a breach with regulation 18. Staffing. During this inspection we did not see any improvement to the current staffing levels within the home and due to the regular usage of agency staff we continued to have concerns that staff were not sufficiently familiar with people's needs.

One person told us, "I'm concerned at the permanent staff that are leaving and being replaced by temporary staff. The language differences can cause difficulties in understanding them." Another person told us, "They are very short staffed." Another said, "The staff are very caring, but they are very short staffed. They are always so busy." This was echoed by lots of people on two of the units on the ground and first floor of the main building. Staff told us they were often redeployed from one area to another. On the other two units' staff and our observations identified concerns with staffing.

One person told us that there had been a real reduction in staff and staff were mentally and physically exhausted. They said, "I wouldn't work here for £20.00 an hour." They said, "When I was first here staff would stop and chat, they don't any more, it's such a terrible shame."

Some staff told us about the numbers of staff leaving and the amount of agency staff working at the home, some were described as good and familiar with people's needs as they had been there before. Others were described as lazy. Staff said that when there was more than one agency staff member working it was difficult to properly induct and support them which had resulted in mistakes being made.

One permanent member of staff told us, "I'm unfamiliar with the systems in the unit, I love working with the people here, they really appreciate what we do.' 'Four carers have handed their notice in two weeks ago. There is a very poor response from the management." Another told us, "I have no idea where I will be working, who I will be working with or how many of us will be working."

A number of health care professionals told us it was not always possible to find staff to ask them for an update of information or to pass information on. During the afternoon inspectors were not able to find staff on the first floor in the main building which is a nursing unit They were concerned because several people were calling out and one person was half in and half out of bed.

On the nursing dementia unit people were not able to tell us about our experiences however we used observations and discussions with staff to assess the adequacy of staffing levels. We spoke to an agency nurse on duty and they told us that they were familiar with the home. We were told that staffing levels on should be at a certain level but were frequently reduced with floating staff trying to cover. The dependency levels on the nursing floor were very high. Staff told us that the majority of people needed two staff to assist them with personal care, moving with a hoist and to eat their meals. In addition the records demonstrated that at times some people living with dementia needed additional staff support when they became distressed, angry or frustrated. This meant that people on this unit had to wait a long time to receive the support and care they needed.

A staff member from another unit told us that although they had time to give people the care they needed they no longer had time to spend with people. We found that agency staff sometimes outnumbered permanent staff and there was not always enough staff to ensure that staff gender preferences were adhered to when delivering personal care. They said the previous weekend there were complaints from family members about staff not responding to their relative's sudden decline in health resulting in them being admitted to hospital.

On another floor staff told us there were enough staff but said some staff were leaving early so numbers were not maintained throughout the shift and they could be incredibly busy. On this floor we found staff were not visible throughout the day. People were calling out and having to wait to have their care needs met and people were not adequately supported to socialise with others or participate in activities of their choice.

On the day of our inspection we saw varying response time to the emergency call bells. We saw some staff ignoring the bell unless it was in 'emergency mode." One person told us, "'The girls are always rushing around. We have to wait for help." Another said, "We need more staff. The ones here are so busy, and if you ring the bell they take so long to come." Some staff reported on feeling rushed where as other staff on the same unit said they had enough time. One person said, "The alarm bells go off all day and I worry about people less able than me." Some bells were out of people's reach and some people were unable to use their call bells. Monitoring charts showed people were checked regularly

Is the service safe?

but were unable to summon staff support if they needed them. One person's call bell had broken at the weekend and had not been fixed. The manager was unaware of this. We saw that this person remained in bed throughout the inspection.

At the last inspection we were told a new tool was being introduced which would assess how many staff were required to meet people's needs according to their dependency levels. There seemed to be some confusion about the introduction of the tool and staffing levels had fluctuated. The regional manager told us they were overstaffed according to the tool but this did not match our observations and what people using the service, staff and relatives told us. The Regional manager told us staffing vacancies were minimal and posts for staff leaving had already been recruited too. They told us 'excessive staff sickness was being managed by the HR department.

We found that the arrangements for staffing did not meet the needs of the people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**.**

People told us that generally they felt safe at the home however in advance of the inspection we were notified of people who were not kept safe and this resulted in safeguarding investigations to establish the facts around people being unintentionally injured or treated in a way that was unacceptable.

Risks to people's safety and health and welfare were not always appropriately assessed or managed. For example risks relating to pressure area care. We found that whilst risk of developing a pressure area were assessed and monitored, staff did not have access to appropriate information about each person to ensure that they received the appropriate care in relation to pressure area management. For example, forms did not tell staff what kind of pressure relieving equipment was required or the appropriate setting. People's weights were not monitored therefore the settings could not be adjusted appropriately risking incorrect pressure care. We observed one mattress, that appeared to be appropriately inflated, had a red 'power failure' light on. Care staff did not know what this meant and had not reported it. Care staff told us that checking the settings was the responsibility of the nurses and did not consider that it was part of their role in preventing pressure sores. Staff showed a very poor understanding of pressure area care.

We received a safeguarding concern around the staff's management of constipation. This is still being investigated so we do not know the outcome. However we did see that medication for constipation was not being given as prescribed. In response to this concern the home had introduced records to monitor this and record changes in people's health in this area. We found that there were gaps in these records and therefore staff would not be able to see if care was always delivered as planned or if the information was effectively evaluated. Staff had not received any additional training when records had been introduced and did not know the significance of the records they were being asked to complete. Information was completed in many different places making evaluation more difficult.

During the day we saw entry to the different units were accessed through a key code system. However the ground floor unit had open access and people could come and go as they wished. During the visit a number of people went outside in to the car park area where there was a small seating area. There was a potential for a person to leave the site unaccounted for. People's outside access on the ground floor dementia unit was restricted as work was underway to create a sensory garden, we observed one person attempted repeatedly to get outside.

We found the arrangements in place to ensure people received safe and effective care were ineffective. This was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were not assured that people received their medicines safety. We spoke with people about their medicines. Two people told us on a recent occasion they had been offered the wrong medicines and were aware of what they were taking so were able to identify this straight away. This is a concern as others within the service may not have been able to identify such an error. One person told us they had cream which they applied externally but said one day a nurse came in with the cream and tried to administer it. They said they reported this and described the panic they had felt as this was not what they expected to happen..

We identified that care staff were not consistently documenting the application of topical creams. We observed a gap of over a week on one form. A member of staff told us that one person needed the creams applied twice a day but it was only recorded as having been given

Inadequate

Is the service safe?

on five occasions in the previous month. Staff were not always recording the date of first use on topical creams. Some creams had been prescribed much earlier in the year. This meant that they may not have been fit to be used as staff were unaware of how long they have been opened.

One person told us they needed medicines to control their pain and did not always receive this. We saw from their records that there was no monitoring of their pain levels. There were documents in their care plan, An Abbey pain scale and pain assessment document, both were blank. However, another person told us that their pain control was good and they received their medicines at the right times

We found medicines were being stored safely for the protection of people who used the service and at the correct temperatures. Audits were in place to enable staff to monitor and account for medicines. However, there were gaps in records of medicines prescribed for external application. We found record-keeping discrepancies for oral medicines that had not been identified by the home's audit and which did not confirm the medicines were being administered as intended by prescribers. The discrepancies included the medicine warfarin which placed the health and welfare of people prescribed it at risk. We also noted that people prescribed laxative medicines for regular administration were not always administered them as prescribed.

Supporting information was available to assist staff when administering medicines to individual people. There was information about known allergies/medicine sensitivities for people living at the home. When people were prescribed medicines on an as required basis, there was information to show staff how to administer these medicines to people prescribed them in a consistent way to meet their needs. However, there was conflicting information about medicines in care plans, information supplied from hospitals and medicine administration records. This could have led to confusion and error.

This is a Breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about safeguarding and how to report concerns if they suspected a person to be at risk of harm or actual abuse. Most staff said the care provided to people was good only compromised at times by inadequate staffing levels. Staff confirmed they had received training on safeguarding and there was information they could refer to about reporting abuse. Staff were aware of external agencies. Staff felt members of the senior team did act upon concerns raised. We saw information about whistleblowing was available in the home and could be seen by visitors and family members should they have any concerns. One staff member told us that there were some staff with poor attitudes and they were still employed within the home. The manager said some staffs performance were being monitored. Other staff had been dismissed after a disciplinary process had been followed

Inadequate

Is the service effective?

Our findings

Relatives told us that they felt staff usually had the required skills but said not all the agency staff were able to support their relatives in the right way. We were told that there were some language barriers and not all staff could effectively communicate with people. One person told us they had used their call bell because they had not had their lunch at nearly two o'clock in the afternoon, an agency staff member answered their call but said they were unable to understand what the person wanted. A relative told us their relative had recently been offered the wrong medicines but a mistake had been avoided because they knew what they should have been taking.

Another relative told us that staff had not responded to their family members needs and it had taken them to intervene. They were not comfortable with the skills and competencies of some of the agency staff. A recent safeguarding incident had occurred with an agency member of staff giving a person a drink which was too hot for them and the person could not manage it safely resulting in injury.

Most permanent staff said their training was up to date and it was refreshed at frequent intervals. They had done safeguarding training and manual handling training and some senior staff were now trained to give medicines to take pressure off the nurses. One staff member told us they had just completed enhanced care qualifications and all their mandatory training was up to date. However they had not done training around specific health care needs of the people using the service such as diabetes, and Parkinson's disease. They had completed training in dementia care.

Some staff members felt that they had insufficient training when roles were changed or they were asked to move to another unit. One staff member said, "I was promised induction training when moving units. I have not had it so far. I feel out my depth."

This is a Breach of Regulation 12: (C) care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**.**

We spoke with a new member of staff who said their induction was thorough and they were shadowed by more experienced staff until they were comfortable. They had done some training but there had been a problem with their log in details so some training had not been complete. They were working through a twelve week induction booklet which was sufficient. They had prior knowledge of the care sector so were confident in what they were doing.

We spoke to the manager about the skills level within the home. The manager said they had eight permanent nurses and were recruiting additional nursing staff. They had done this successfully and were just waiting for a disclosure and barring check, (DBS) They told us about a new award that they would be using to support care staff and enhance their job skills so they could effectively support the nurses and carry out some additional tasks traditionally undertaken by nurses such as minor dressings and catheter care. Staff skills and competencies would be closely linked to CQC requirements and would look at essential skills and characteristics including effective communication and compassion in care giving. Training was being rolled out to the manager and nurses who would them be responsible for supporting care staff once they had the required levels of competence.

Since the last inspection some staff, (eight) had completed training in the malnutrition universal screening tool, (MUST) and this was being rolled out to other staff. This helped staff identify who was at risk of malnutrition and how to use screening tool to identify people who could not be weighted.

We observed lunch on several of the units and asked people if their dietary needs were met. People's views on the food varied from poor to very good. One person said, "The food is awful. There are two choices plus a diabetic option. There are three chefs but very little variation in what is provided." Another person said, "The menus are a bit repetitive." And one person told us they only like the meals 'occasionally'

People also told us some good things; One said "I have a good breakfast and a sandwich for lunch, followed by and omelette for tea. That suits me.' A relative told us, "My mother likes the food and has put on a stone and half since coming here.'

We found the dining experience varied, in one unit it was quiet with little interaction, in another unit the people requiring assistance got served first which meant other people were waiting a long time. One person told us they were getting hungry and couldn't remember what they had ordered for lunch. In another unit staff were not as familiar

with people's needs. Staff told us agency staff had to be watched and reminded who had a special diet otherwise mistakes could be and had been made. People had been asked their menu preferences but were not given a choice at the time of their meal and we did not see staff use food plates or picture menus to help people decide what they wanted. We noted that whilst people were being assisted with their meal staff left to answer call bells, this did not enhance people's dining experiences.

People's nutritional intake was not adequately monitored. Staff referred people to the GP and dietician if they had significant unplanned weight loss. However, they appeared to only assess weight on a month to month basis. They did not record people's weight over a period of time in order to assess total weight loss. The information was not brought together for each unit to help staff audit the number of people at risk of malnutrition and the effectiveness of their nutritional support. This meant that they did not always identify people who were steadily losing weight over a period of time or those with a very low but stable BMI as needing support. If people were gradually losing weight but had a 'normal' BMI staff did not always take action to try to reverse the continuous weight loss.

One person had lost 13.4 kg in a period of just over six months. However, there was no evidence that they were consistently being offered nutritious snacks and high calorie drinks between meals. They were only offered a cup of tea mid-morning with no snack. A senior member of staff told us that they fortified people's breakfast if they were losing weight but could not tell us whether all staff consistently did this.

The nutrition records were not always detailed enough to assess the adequacy of people's nutritional intake. They included very little evidence that staff were consistently supplementing or fortifying people's diets when they had a low BMI or were losing weight. When people refused a meal staff were not always recording the alternatives offered or whether the next cup of tea was replaced by a nutritious drink and high calorie snack. Food charts varied and showed gaps without exception.

We found the arrangements for meeting the nutritional and hydration needs of people unsatisfactory. This is a Breach of Regulation 14: of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**.**

Recent concerns had been expressed about the decline of a person's health resulting in them becoming dehydrated, unresponsive and requiring hospital admission. As a result of concerns relating to this and another concern relating to poor pressure care for another person and poor management of constipation for another person the home had introduced further monitoring of people's health to ensure their needs were being monitored and met. However staff told us that agency staff did not complete these records, this was down to the permanent staff so when they were short of permanent staff it was difficult to keep records up to date. We found the home was reactive rather than proactive when it came to meeting some people's needs. For example we were told a family member that urine infections were not always identified quickly enough by staff and this resulted in prolonged treatment of antibiotics. Fluid charts were not accurately recorded and we found on some days entries were not regularly recorded which made it difficult for us to monitor if people had adequate levels of fluids.

Care-plans showed us how people's health care needs were monitored and reviewed monthly. Changes reported had been followed up with referrals made to the GP and basic checks carried out to ensure the person did not have an infection. However this was not always effective. We looked at one person's records which showed that a decline in their health had been reported by their relative and not identified by staff. Another person's records indicated that their health had also declined and had not been identified. A number of people had a sickness and diahorrea bug which had put them at greater risk. This was not being managed effectively because it had not been contained to one area of the home but had affected more than one person in different parts of the home. Whilst at the service we were advised that a few people were affected upstairs but there was no information for staff or visitors about minimising infection and we saw no hand gel other than in the bathroom. We also found some areas of the home visibly dirty with an odour of urine.

We found that a person with significant health concerns had not yet seen a GP in spite of staff booking appointments over a week earlier. This person's records did not accurately reflect their current conditions despite a rapid deterioration in this person's health. Their record described them as low to medium dependency but we noted variations in the amount they ate and drank and their skin was significantly compromised with sores

Inadequate

Is the service effective?

developing and a painful rash, staff said as a result of being unwell. Their records indicated they had not been weighed for two months and they had not seen a dietician and it was not clear how the risks to this person were being managed. Records did not reflect accurately how this persons needs were changing over a short period of time. .

One person had a suspected infection and had been in a lot of pain. They told us that they had been seen by several District nurses and given antibiotics but were not yet improving. They were waiting to see their GP and were concerned that they had not been seen yet. The pain they were in had not been effectively managed and records confirmed this. They were really unhappy with the position they were in so we fed this back to the manager.

We found that the arrangements for monitoring and meeting people's health care needs were not always adequate. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we received concerns about people not always being adequately supported in terms of their decision making or where they might lack capacity the home had not make appropriate decisions or referrals to the local Authority. We spoke with one family member who was happy that the home had responded appropriately to a change in their relative's capacity and the person had been deemed as unsafe to go out by themselves. The rationale for this was recorded and they had been assessed and agreement was reached with involvement of all relevant parties and the relevant documentation was in place The manager agreed that the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were poorly understood amongst the staff and training was being rolled out to the whole team. For some people there had been a note to say they had 'no capacity,' How this decision had been reached was not documented within their records. There was no assessment or advanced care plan to support those people, or staff with decision making. We saw in other records it was documented that people had fluctuating capacity. Primarily due to infection. There was not a consistent approach to recording people's lack of capacity within the home. We found that all of the people who resided upstairs were restricted in their movement and freedom and the manager had made appropriate DoLS applications to the Local Authority.

Requires improvement

Is the service caring?

Our findings

Care and domestic staff were generally observed as being kind and compassionate when given the time. One person said, "The girls do look after me. If you are nice to them they are nice to you." Another lady said, "The domestic staff are really good." One person said, "I don't' like it here but the staff are very kind." Another person told us, that they were treated with respect and dignity and they had been happy at the service but said in the last two months things had changed and staff had left and seniors moved on. They told us they were less confident about the service now. We spoke with one person who told us staff were very kind to them and had given them a bath this morning

We spoke with a family member who told us their experience had been nothing but favourable. They described staff as, 'Very good, interactive and caring.' They were concerned that at times staff confided in their family member about the level of service and a number of their 'favourite' staff were leaving.

We observed a person who required assistance to eat their food; the carer was very sensitive and spoke with them gently whilst encouraging them to eat more of their meal. On the whole care staff were sensitive to people needs but some of the language used was not very dignified. For example, one staff said in relation to meals, "We got the pureed coming up first."

Friends and relatives had free access to visit relatives and during the visit a number of relatives came and took their relatives off site or sat outside the main entrance. Some spent time with them in their rooms. However, some residents said that they had no visitors and never ventured beyond the home.

People's privacy and dignity was not always promoted. After lunch we found there were no staff to be seen on the first floor in the main building and this was reported to the regional manager. At a different time there was a handover taking place between the morning and afternoon staff and only one member of staff was free to respond to the alarm bells, the staff member needed help and pressed the person's alarm again, no one came so they had to go and look for staff resulting in the person waiting for their care. One person told us that said their "dignity had gone out of their window?" This was because they had waited too long for toileting assistance and now needed additional personal care. We saw a person with a catheter bag which was hanging down beside them in full view. We asked them about their day and they told us, "I dare not go into the dining room to eat because of my eye sight, I might not have anything on my fork and other people might stare at me."

We saw that there was a charter on how staff should respect people's dignity and rights and what people should expect from the service. Dignity advisors had been identified and staff were encouraged to promote people's dignity by having a dignity pledge which staffs performance was measured against.

Family members confirmed they had been kept informed about their relatives care needs and invited to give feedback but had not seen care plans. We did not see peoples involvement reflected in their care plans.

People were consulted about their views. There were a number of ways in which this was done. There was an electronic machine in the main entrance, and an I-pad was made available for people to report their concerns and feedback. Resident and relative meetings had been held although these were not always well attended. There was an annual quality assurance process which routinely asked people using the service, their families and staff about their experiences of the service which could then determine what people were happy with and what should be done to improve the service. In the main reception there was information about what people had said as part of this annual survey and what the home had done about it. The manager said they also did a daily walk about.

We found that a lot of people would not be able to report on their experiences in the home without relying on others. We asked staff about advocacy services and staff told us, 'we advocate for people' or their families do. This is not the true spirit of advocacy which should be an 'independent person' not related to the person or providing direct care to them. For those who were able to tell us about their experiences the feedback was very mixed. A number of people said what they would really like to do is go on visits outside the home. One person said, "We never get out of this home, trips out would be really nice." Another said, "It would be nice to go and visit places." Another said, "It would be nice to go out for the day and see something other than four walls." We saw no evidence that people's wishes were met.

Requires improvement

Is the service responsive?

Our findings

We observed social activities taking place but saw these had been significantly reduced since our last visit with only one activity planned for each day excluding Sunday and the majority of people at the home did not participate in what was on offer. We looked at the weeks programme provided by the activity coordinator. This included several sessions of bingo, games, a nine letter word game, flower arranging and a visit from a pat dog. One person said, "I like the activities here." Another said, "The bingo is very important to me. " They told us it was the highlight of the week. Another person said, "I am not really interested in the activities. Computer games would be a good idea." One person told us activities were reduced, they said last year staff would take them for a walk and said this doesn't happen now.

The people participating in bingo seemed to enjoy themselves and played for small prizes. However most people stayed in their room and we felt the activity programme did not really accommodate the needs of people with dementia or those with cognitive impairment. We saw little opportunity for staff to spend time with people and engage with them throughout the day other than around tasks people needed assistance with. The programme was not sufficiently varied to accommodate their individual needs and preferences.

One person said to us, "They don't know me as an individual. If you don't need anything you don't see anyone. The care staff are helpful but under pressure." Another said, "I am frightened that I will be thrown out if I need too much help." In people's room we saw a place to record people's individual preferences but some of these were blank or just gave information about tasks staff had carried out to monitor their health and wellbeing.

On another unit, one person told us, "There's not much to do." According to the activity programme the care staff were supposed to carry out activities on three mornings a week but staff said that they were too busy to do this. There were activities identified on only two afternoons in the week. People in the communal areas had very little stimulation and interaction from staff during the day. Staff told us on some day's activity staff were supported by volunteers and students. One person told us, "There are no activities, nothing to do. There used to be two activity chaps now there's only one, they can only do one thing at a time, they are doing their best. You get use to the activities and eventually you look forward to them. "

This is a Breach of Regulation 9: of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**.**

The manager told us they were replacing the care plans so they were easier to use. Staff told us, 'They will be like they use to be.' We learnt that there was no schedule for how quickly these would be introduced and were told, 'They will take as long as they take.' New people using the service had the new style care plans. The manager was due to go on some training on using the new care plans but none of the other staff had received training despite these having already been introduced. At the last inspection we reported on the care plans and stated in our report, that care plans did not tell us about the person's emotional and psychological needs but focused on their medical needs and task focused care. They were not easy to navigate.

We looked at a sample of records again during this inspection and saw that care records were of a variable standard and were not person centred. They did not always provide a clear indication of people's needs, preferences and abilities or indicate how staff supported them to maintain their independence. The care records were extremely bulky and repetitious. Nurses and care staff recorded information about people on each shift but in different places. This meant that there was a lack of continuity in the records that could have impacted on the consistency of care provided.

Daily records did not really help us decide if people received the care and support they needed and in line with their care plans. They were very limited in detail and did not reflect on people's day to day experiences or always show the care being given. For example one person needed help with personal care and liked regular showers. We could see that they were occasionally supported to have a shower but not regularly and there were no entries about personal care.

Some care plans were incomplete, partially complete and not always dated or signed. We saw that a person who had already been at the service for a third month had incomplete records in relation to their needs.

It would have been very difficult for new or agency staff to find the key information about each person. There was no

Requires improvement

Is the service responsive?

summary for them to refer to. For example, one that included people's main medical diagnoses, major risks, key care needs, their abilities and particular preferences. The manager had a very brief information sheet that was given to agency staff but it did not provide key information. Some care plans had general statements that were not always appropriate for the individual person. For example, one person with a BMI of 14 had a nutritional care plan which stated that they "Need a well-balanced diet to help minimise weight loss or weight gain."

This is a Breach of Regulation 9: of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**.**

One person, who had recently arrived at the home, had very swollen legs. They told us that they needed to have their legs elevated and that this formed part of their assessment. They told us that staff said there were no footstools. We raised this immediately with the manager so they could rectify the situation. Another person with visibly swollen legs told us staff used to elevate their legs in the afternoon but said this had stopped now and said, "Staff don't even ask me. "They asked us to share this with the manager which we did. Another person told us they were okay at the home but felt concerns they had raised as part of the recent residents meeting had not been addressed as yet. They raised issues about not having enough opportunity to do exercises which they felt meant their mobility was reduced, issues about laundry and missing clothes and the fact they needed something in town and despite asking had not been taken by staff. They felt that the service was not meeting their needs as a relatively independent person. We spoke with another person who was deaf in one ear and the hearing aid for the other ear was out of battery. They were waiting for their daughter to resolve this and meant they were having difficulty in talking with us, but wrote things down. It also meant that they did not feel they could participate in activities provided in the home. Another person had a note outside their room advising staff to put the radio on, radio two, the radio was not on.

There was evidence that staff communicated well with relatives when there any health concerns, incidents or accidents. However we learnt that relatives were not always able to get through at a weekend as care staff did not always answer the telephones. Health care professionals raised the same frustrations.

Requires improvement

Is the service well-led?

Our findings

The staff spoken with did not feel well led by the provider which was evidenced by the number of agency staff and those more experienced staff leaving for other jobs elsewhere in the care services. One member of staff said they felt let down by the provider after a number of years working for the home as things had been allowed to get worse and the manager had little support to make it better. One member of domestic staff said they liked working here and enjoyed her role.

Some staff told us the manager was visible in the home and walked round every morning. One member of staff said they knew how to raise concerns but did not feel they were acted upon. One person told us about the recent changes in the service which they said were detrimental. They said in relation to agency staff. "I wouldn't trust them to empty my bin." They said they had not been kept informed as to why changes in staffing had occurred or what benefits this had brought to people using the service. A number of people said their concerns had not been responded to.

The manager told us they were holding meetings and were supported by their regional manager in terms of developing the staff team and stamping out poor practice. The regional manager had been in post about ten months. Over the last six months there had been a number of allegations of poor staff practice and these had been addressed. However the records did not clearly show us the outcome of each investigation and we have some more information from the manager. We were able to see what had been introduced as a result of incidents in the home which meant mistakes were learnt from.

Staff told us there was an annual review of their progress and they were asked for their feedback which gave them an opportunity to share their concerns or what was good about working at the home. Some staff felt their concerns were not addressed or always received sympathetically. Some staff said there was no incentive for working hard and they did not get the recognition they would like.

The manager said their support had improved with regular meetings with other managers employed by Four Seasons. A new human resources department was in place and supporting the manager in addressing staffing practice issues The manager said they were also involved in 'Home Life' an initiative run by the Local authority which aimed to support managers and put them in touch with other managers to gain support and share ideas and good practice.

Although the manager reported favourably about their support and improvements introduced to the service we had concerns about people's experiences which varied across the home as did staffs experiences across the home. We found people were generally disengaged with a reduction in opportunities to participate in activities, and these activities were not frequent enough or designed around people individual needs. Staff morale was low affecting people's experience of care and risks to people's safety were not adequately monitored or acted upon. Medicine audits were not sufficiently robust and we could not be assured people always received medicines safety or that medicines were used effectively as prescribed when necessary.

We found that although there were systems in place to regularly engage and consult with people about their care and wishes some people were unable to contribute to this process and others felt that when they had raised issues these had not been addressed and people raised things with us on the day which were important to them and they wanted addressing. The service could not demonstrate how they sustained improvements made previously as part of our inspection processes. Our reports highlighted the same or similar issues. Medicines were a good example of this where we have escalated the action we have taken in line with our enforcement practices by issuing compliance actions and a warning notice twice in the last few years.

In the main reception people could submit their feedback electronically and anonymously if they wished. This was printed off and enabled the manager and head office to see what was being raised and to give them a change to respond to concerns or positive feedback about the service. The manager said staff were told to encourage people to raise concerns and could use the I-pad to record people's concerns. However people felt this was then not taken into account and what they wanted was continuity of care and more opportunities to 'get out.'

In addition the manager said they had started to meet regularly with the different GP practices to ensure they were working effectively together for the good of the people using the service.

Requires improvement

Is the service well-led?

Some people we spoke with, staff and relatives were aware of the outcome of the last inspection but the ratings for the last inspection although displayed in the home was not displayed in a prominent place at eye level.

In July the results of surveys were compiled and showed people had been consulted on a range of issues within the home, the findings were circulated and the home had a 'You said we did' and this was displayed by the entrance. There was also information about if people needed help to complete the surveys they could ask their family or a member of staff. We were unable to see from the information received what the response rate was and how many surveys were returned. The outcome of the survey would be discussed at the next resident/relative meeting which was scheduled for September 2015, the previous one had been held in June. Feedback about the care was positive with people feeling that staff respected their privacy. Concerns were raised about food, laundry and staffing.

We saw a sample of audits and spot checks completed by the manager including care plan audits, medication audits, As a result of this audit, actions were identified and who needed to address the issues by when. For example we saw an audit which identified that all air mattresses needed to be checked and have the right settings to ensure people's health and safety. This was identified in July but was an issue for us in our August's inspection so we could not see how robust actions taken were.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not protect people against the risks by way of doing all that is practicable to mitigate any such risks. Medicines must be administered accurately, in accordance with any prescriber instructions and at suitable times to make sure that people who use the service are not placed at risk. Regulation 12 (2) (b).

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; Regulation 17, (2) (c).

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure that the staff had the right competencies and skills to deliver the care required and equipment was not used in a safe way so we could not be assured risks to people's health and safety were fully mitigated. Regulation 12, (2) (c) (e).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The service did not always ensure people had their nutritional and hydration needs adequately met because there was poor monitoring of this over a period of time putting people at increased risk of unplanned weight loss. Regulation 14 (2) (b).

Regulated activity	Regulation
	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service did not always ensure the care and treatment of people was appropriate and met their needs Regulation 9 (1) (a) 9 (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service did not design care and treatment with a view to achieving service user's preferences and ensuring their needs were met. Regulation 9 (3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced person were not deployed.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced person were not deployed.**

The enforcement action we took:
We served a warning notice