Care Quality Commission

Care UK Community Partnerships Ltd

St Vincents' House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
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?	Requires Improvement

Overall summary

This inspection took place on 2 and 3 March 2015. The first day of the inspection was unannounced and we informed the registered manager we were returning on the second day. At our previous inspection on 1 August 2014 we found the provider was not meeting the regulation relating to the provider having effective processes to seek the views of people living at the service and their representatives, in regard to the quality of the food service.

St Vincents' House is a 92 bedded care home with nursing and provides care, accommodation and support for older people with general nursing care needs, people who are living with dementia and people with palliative care needs.

The service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People and their relatives told us there were not always enough staff on duty to keep people safe and meet their needs.

People told us they liked the staff and felt safe with them. Staff had received safeguarding training, although some staff needed more support and guidance in order to fully understand the provider's whistleblowing policy.

The service conducted risk assessments to ensure people were safe, while taking into account their wishes and rights.

People were protected by rigorous staff recruitment practices. Staff received training, support and supervision to carry out their roles and responsibilities. However, improvements were needed to ensure that the supervision was meaningful and focused upon staff member's individual circumstances.

There were robust systems in place to ensure people were safely supported with their medicine needs.

We were informed by staff that sometimes they did not have enough equipment such as hoists, gloves and incontinence pads; however, satisfactory supplies were available on both days of the inspection.

Improvements had been made to the quality of the food service, although some on-going work was needed to ensure that the food was consistently served at the correct temperature.

Most staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which care homes are required to meet. The service understood how to act within legal requirements when determining if people needed to be deprived of their liberty to keep them safe.

People's healthcare needs were identified in their care plans and they were supported by the service to meet these needs.

People told us that staff were kind and talked with them. We observed that some staff appeared to be more task orientated when they provided care and did not offer a more personalised approach.

Although people and their relatives told us they took part in activities we saw limited evidence of this during the inspection.

People's dignity and privacy was promoted. We saw that staff knocked on people's doors before entering and closed doors if they were providing personal care.

There were systems in place to regularly review and update people's care plans.

The service had systems in place to meet the needs of people who were at risk of developing pressure ulcers. However, there were gaps with the recording of the preventative care and how the staff treated pressure ulcers.

People told us they had received information about how to make a complaint and thought that the registered manager would respond well to any concerns.

People and their relatives told us they could speak with the registered manager and most people thought that the service was well managed.

Some staff expressed concerns to us that they did not feel consulted or valued by the management team.

The provider carried out surveys and audits in order to improve the quality of the service.

We found two breaches of regulation, relating to sufficient staff on duty to ensure people's safety and ensuring that people are always treated in a caring and compassionate way.

You can see what actions we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe. There were not sufficient staff to ensure that people were safe and their needs were met.

Staff understood how to protect people from abuse but some staff did not fully understand the provider's whistleblowing policy.

Risk assessments were in place to promote people's safety.

Medicines were safely managed.

Staff reported that they did not always have enough equipment to safely care for people.

Is the service effective?

Requires Improvement

The service was not always effective. Staff received training for their roles and responsibilities but needed more detailed and focused supervision.

Staff had received training and guidance in regard to Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA), although some staff told us they needed more guidance. The provider acted inaccordance with legal requirements when people did not have the capacity to consent.

The care plans showed that people's health care needs were understood and addressed. People were able to access support for their healthcare needs.

Is the service caring?

Requires Improvement

The service was not always caring. People told us staff were kind and caring. However, we saw that some staff worked in a task orientated manner and did not speak with people in a personalised way.

People received care that promoted their entitlement to privacy.

People were offered opportunities to engage in fulfilling activities, although these opportunities appeared limited during the inspection.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. People received the care and support they needed as care plans were comprehensively written and up to date.

The service responded to people's pressure care needs but documentation was not consistently thorough.

People knew how to make a complaint and the service had appropriate systems for investigating complaints and concerns.

Summary of findings

Is the service well-led?

The service was not consistently well-led. Most people told us that the service was well managed and they had confidence in the registered manager.

People and their representatives felt their views were sought and listened to.

Some staff told us they did not feel consulted and valued by the management, which impacted upon staff morale. Robust systems to seek the views of staff were not evidenced.

The service carried out audits and checks to improve the quality of the service.

Requires Improvement

St Vincents' House

Detailed findings

Background to this inspection

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

This inspection took place on 2 and 3 March 2015. The first day of the inspection was unannounced and we informed the registered manager we would be returning for a second day.

The inspection team consisted of three inspectors, a specialist professional advisor with experience in the nursing care of older people and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience had experience in the care of older people.

Before the inspection we looked at the information the Care Quality Commission (CQC) holds about the service. This included notifications of significant incidents reported to CQC and the last inspection report of 1 August 2014, which showed the service was not meeting all regulations covered during the inspection.

During the inspection we spoke with six people using the service and six relatives and friends. We spoke with 13 staff including members of the senior staff team, the registered manager and the area manager. We observed care in communal areas and reviewed records which included 10 care plans, medicines records, staff records and records relating to the management of the service. We also checked five staff recruitment, training and supervision files.

Some of the people living at the service had dementia and were not fully able to tell us their views and experiences. Because of this we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with a GP from the practice which provided medical support for people using the service and a clinical nurse specialist from a hospice that provided people with palliative care support. We also contacted Central West London Healthwatch, which sent us information.

Inadequate

Is the service safe?

Our findings

We received mixed responses about the staffing levels from people using the service and their relatives. People commented, “Sometimes they are a bit short of staff”, “They are short staffed, particularly in the evening” and “They [staff] come quite quickly and always get me to the toilet.” One relative told us they thought there were not enough permanent staff and their family member found it difficult to adapt to agency staff. Other relatives commented about how busy staff appeared. One relative said they had concerns about the staffing levels because they often observed their family member needed immediate personal care due to incontinence, when they arrived at the service for a visit. Other relatives told us their family members were well cared for.

Staff told us that although the staffing numbers allocated to each unit were sufficient, there were often staff absences which meant that frequently there were not enough staff on duty to attend to people’s needs. This was described as being a particular problem at busy times of the day and when staff needed to support people with more complex needs, for example people who needed two members of staff to support their personal care. Some staff said it was often difficult to take scheduled breaks as this would leave people at risk when there were staff shortages. Staff commented that staff shortages tended to be worse at weekends and said there were no reliable contingency systems to ensure that extra staff could be provided at short notice. Comments from staff included, “We’re doing double jobs. Residents are kept in bed when we are short staffed” and “Sometimes we are short staffed. The take staff from one floor and send elsewhere.”

On the first and second day of our visit we saw that there was only one staff nurse on duty on Balmoral unit, although the clinical lead told us that there should have been two staff nurses. On the second day, we saw that the staff nurse from the night duty had remained at the service and was undertaking the morning medicines round.

We observed that some people remained in their rooms for a large part of both days on all units and staff were not visible on the floor to attend to people or check on them. We did not see staff spending time with people in a social way, for example having a chat or engaging with them in an activity such as looking at a newspaper together. Central West London Healthwatch informed us of similar findings.

We observed people being supported at lunchtime on the unit for people living with dementia. Two members of staff supported six people. The interactions between staff and people were limited as the staff were busy. One person did not get the support they needed as the staff were assisting other people to eat and drink. They were given their lunch (a hot meal) at 12.50 pm but no member of staff was available to assist them until 13.10 pm. By this time the meal looked congealed and unappetising.

We spoke with the registered manager and the area manager about staffing levels. It was acknowledged that difficulties arose when a member of staff went off sick at short notice and the service could not find bank or agency staff to cover the shift. The registered manager told us that the clinical lead and/or the co-ordinator for care staff worked on the units to cover staff shortages which was documented on the staffing rotas, but this was disputed by some members of staff. We were told that there was one vacancy at the time of this inspection for a staff nurse and interviews had already commenced. We were also aware that a member of staff had been suspended.

Our observations showed that the staffing levels in the home were not sufficient to respond to people’s holistic needs including social interaction and stimulation, and there were not enough staff to provide people with the support they needed at the time they needed it during lunchtime. This meant there were not enough staff to ensure the welfare and safety of people who lived in the home.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they felt safe. Comments included, “Yes, I feel safe in here. The staff are very kind, they talk and listen to me” and “I feel safe and comfortable. All the staff are helpful although some are more patient than others.” One relative told us, “This place is entirely safe and the staff are very pleasant” and another relative said, “The staff are so kind, unbelievably patient. It is very safe and I am happy [my family member] is here.”

There were systems in place to protect people from the risk of abuse. Staff informed us they had been trained in safeguarding, which was demonstrated in the training records. Staff were able to provide definitions of different

Is the service safe?

forms of abuse and told us they would inform their line manager if they witnessed abuse or suspected that a person was being abused. Some care staff were not aware of how safeguarding allegations were investigated, although this information was explained in the provider's safeguarding policy. There was a copy of the safeguarding policy in the staff office on each unit for reference.

Although most staff were aware that there was a whistleblowing policy, some staff told us that they were not familiar with the policy and were not sure how they would be protected if they raised concerns about the service. This lack of information meant staff might be reluctant to appropriately use the policy to whistleblow. The provider informed us that whistleblowing had been recently discussed with all staff and they could easily access the whistleblowing policy.

Providers of health and social care services have to inform us of important events which take place in their service. The records we hold about this service showed that the provider had notified us about any safeguarding incidents and had taken appropriate action to make sure people who used the service were protected.

Each person had an individual care folder which contained an assessment of risks. This was not included in the electronic system of care records and therefore had to be accessed separately as a hard copy record. Assessments covered different aspects of care, including environmental risks, physical risks, behavioural risks and risks related to medical conditions. The assessments also contained details of ways to minimise or avoid each identified hazard or risk. Risk assessments were usually reviewed and evaluated on a monthly basis, although we found a few that needed to be updated.

The staff recruitment files showed that staff were safely recruited. Each file contained appropriate checks to make sure the staff were suitable to work with people using the service, which included criminal record checks, two verified references, proof of identity and proof of eligibility to work in the UK. The staff files for registered nurses contained documentation to demonstrate that the nurses had valid registration with the Nursing and Midwifery Council (NMC).

We observed part of the lunchtime medicine round on Balmoral unit and saw that people were supported to safely take their prescribed medicines. A visiting GP told us that there were appropriate systems in place for providing medicine covertly when required and that authorisation forms were always signed by the GP after best interests discussions.

Balmoral unit used a Medicines Administration Record (MAR) charts handover form, which required a staff nurse to sign that the MAR charts had been checked each shift for omissions. This checklist had been signed for in February except for two days. Omissions were also seen on MAR charts for these dates and the unit manager confirmed that agency staff nurses had been on duty on these dates. The unit manager told us that they had reported these findings to the clinical lead nurse.

Pain assessment charts were completed and people were asked about their pain and if they required additional medicines. There were two types of pain assessment charts in use; one for people who could communicate verbally and one with pictures for people who had difficulty speaking. This meant that people were being supported to report if they were experiencing pain in a way that took into account their communication needs.

Medicines were correctly stored and there were protocols for safe disposal. Liquid medication and eye drops that had been opened had the date of opening recorded on the bottle. Liquid antibiotic was stored in the fridge as appropriate. The controlled drugs (CDs) were stored appropriately in a locked cupboard that was alarmed. The CD stocks were checked each shift by two staff nurses. We checked the stock levels for two CDs, which were found to be accurately recorded. The unit manager explained the process for the disposal of medicines and records were seen. A disposal of medicines kit was seen in place in the treatment room.

We observed that the British National Formulary (BNF) on the unit was dated March 2012. The BNF is a pharmaceutical reference book written by the Royal Pharmaceutical Society. This meant that unit staff did not have easily available access to any recent information about the prescribed medicines they were administering.

People and their relatives told us that the premises were usually clean. One person said, "It is clean, spotless" and another person told us, "They [housekeeping staff] clean my room every day."

Staff told us they received regular updates on infection control. We spoke to a member of the housekeeping staff

Inadequate

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who explained to us the colour coded system for cleaning equipment and we saw staff using the colour coded system. Sluice rooms were clean and uncluttered and were locked, as were cupboards used for storing cleaning equipment and Control of Substances Hazardous to Health (COSHH) materials. Some staff told us that there were not always enough yellow disposal bags available.

We spoke with the maintenance person about their role and responsibilities. We looked at some of the maintenance and safety records, which included the regular checking of water temperatures, room temperatures, the nurse call bell system, the emergency lighting system, fire equipment and security of the premises.

All areas of the home appeared clean and bathrooms had modern fixtures which were appropriate for those using the service. Staff wore protective aprons and gloves when delivering food at meal times, and hand disinfectant dispensers were available in communal areas. However, staff told us they did not think there were sufficient supplies of incontinence pads, disposable gloves and plastic bags for the disposal of items such as used gloves, wipes and incontinence pads available at all times.

A visiting healthcare professional told us that the blood pressure monitoring equipment was not always in working order. Several staff said that there was a shortage of chairs used for weighing people, which meant additional staff time was spent acquiring a chair from another unit. We discussed this with the registered manager who told us that one of the two chairs used for weighing people was broken and awaiting repair. We received information from the provider after the inspection to confirm that the broken chair had been repaired and was being used again.

Requires Improvement

Is the service effective?

Our findings

People and their relatives were mainly positive about the quality of care and support. One person using the service said, "Staff know what they are doing, they are very good" and another person told us, "They know what I need and provide it." Comments from relatives included, "Staff are well trained and competent", "I think this care home is much better than the previous one, it's a 10 out of 10" and "I do not feel 100% that the care is good. I have no evidence but I feel care could be much better."

We looked at staff training records which demonstrated that staff attended a wide range of mandatory training, which included moving and handling, fire safety, safeguarding adults, basic life support, and how to support people with behaviours that challenge. Staff files showed that new employees received an induction and completed a programme of training during their probationary period. There were opportunities for care staff to enrol upon national qualifications in health and social care, and experienced staff could undertake courses to develop their leadership skills, such as train the trainer.

Some staff told us that they did not find their one-to-one supervision useful. One member of staff told us they were handed a piece of paper by their supervisor and asked to sign it. The supervision records we looked at showed that some one-to-one meetings for different staff appeared almost identical, although other supervisors demonstrated a supportive and individual approach. We saw that some staff had attended supervision four or five times in 2014. The registered manager told us they recognised that the quality of supervision needed to improve and all staff that provided supervision had been booked on to a training course in March 2015, about how to deliver effective supervision.

Training records showed that staff received Mental Capacity Act 2005 (2005) and Deprivation of Liberty Safeguards training. Some staff we spoke with had a good understanding of the Mental Capacity Act 2005 and others told us they needed more training and opportunities to discuss this topic. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. Most staff we spoke with understood this and could provide examples of how they applied their knowledge and understanding when supporting people with their care.

The MCA includes decisions about depriving people of their liberty so that if a person lacks capacity they get the care and treatment they need where there is no less restrictive way of achieving this. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to do so. As St. Vincents' House is registered as a care home, CQC is required by law to monitor the operation of the DoLS, and to report on what we find. The provider was in the process of reviewing people's needs and was aware of how to make applications to the supervisory body. The registered manager told us they liaised with the supervisory body for advice and guidance, as necessary. We saw that best interests discussions had taken place or been documented for some people who lacked the capacity to make decisions.

At the previous inspection in August 2014 we found that the provider was not consulting with people and their representatives about the quality of the food service. Comments from people about the food service at this inspection showed that their views were being listened to and acted upon. One person told us, "Yesterday the roast beef was excellent. Generally the food is very good and I like mealtimes. Drinks and snacks are provided regularly." Another person said, "The food is good. I feed myself and I look forward to food." One relative told us, "[My family member] has a very hearty appetite and enjoys and looks forward to [his/her] food." Another relative told us, [My family member] has always said the food is very good and always eats it." We heard some negative remarks about the food. A relative said, "[My family member] does not like the food. [He/she] tends to refuse food. It does not smell or taste good."

We spoke with the chef who told us about the changes to the food service. The majority of the meals were delivered to the premises; however, people were now being provided with some freshly prepared items such as daily soups and home baked cakes. People were also offered alternatives to the main meals, for example omelettes and salads, which were made on the premises by the chef. The chef and registered manager told us that people had commented favourably about these changes to the food service.

Requires Improvement

Is the service effective?

We were shown food quality surveys carried out by the provider, which were carried out every month. These surveys demonstrated that an increasing number of people thought that the food had improved since our previous inspection visit last year.

Nutritional assessments were carried out for each person living at the service. We saw that there were Malnutrition Universal Screening Tool (MUST) assessments in all of the care plans we looked at. Any risk of malnutrition was recorded and appropriate measures were documented in the relevant care plan, including triggers for referral to a person's GP if their weight or fluid intake fell below acceptable levels. This meant that the service had clear guidelines for supporting people to receive appropriate nourishment and hydration.

People's weight was checked every month and we saw electronic and hard copy records of regular weight monitoring. Food preferences and dietary requirements such as soft food, assistance to eat or swallowing difficulties were documented. Daily food intake and fluid charts were up to date. Staff told us that jugs of water were available to people in their rooms and in communal lounges to avoid the risk of dehydration, and hot drinks were available throughout the day.

We heard a relative complaining that the hot food provided was cold and therefore unappetising by the time it was served, as plates were not heated. This was a particular problem for those who had meals taken to their rooms. We checked plates used to serve hot food at lunch time in one of the dining areas (ground floor) and they were cold. When questioned about this the care staff put the plates in a microwave to heat them. However, the food surveys demonstrated that this was not a regular occurrence. We spoke with the registered manager and regional manager about the use of cold plates. We were assured that this was not in keeping with the provider's policy and would be addressed with staff.

People and their relatives told us they were able to access care from external healthcare professionals. Comments included, "All his/her healthcare needs are met. The chiropodist comes every six weeks", "The GP comes every Tuesday but you can see them at other times" and "His/her healthcare needs are well met."

Visits from healthcare professionals were recorded in a separate section of the electronic care records and were well documented. A local GP visited the service on a twice weekly basis, or more frequently if required, for consultations with people or to conduct general health or medicines reviews. We saw that details of these visits were recorded in a separate diary kept in each unit's office and were told that a record of each visit was also input into the practice's own electronic system. The GP told us they did not have any concerns in regards to nursing staff promptly referring people for consultations and how nurses followed up any medical instructions. People using the service were also supported by weekly visits from a consultant geriatrician, which enabled people to access specialist medical advice, assessment and treatment.

The care plans contained contact details for other health professionals such as opticians, audiologists, dietitians, and dentists, and details of hospital appointments and relevant correspondence. We also saw referrals to community teams for specialist equipment, wheelchairs and pressure relieving equipment.

Requires Improvement

Is the service caring?

Our findings

People and the relatives we spoke with were generally positive about the conduct and attitudes of staff. Most people told us that although staff appeared busy, they usually came into bedrooms to greet people and ask them how they were. Comments included, “Some of the staff are lovely. They come in and talk to me every day”, “They do look after [my family member]. The activities lady visits [him/her] at least every week” and “They will make a big effort to say hello to [my family member] when they come into the room. They are very nice.”

However, despite these positive comments we found that staff did not always interact with people in a caring manner. We saw that although some care staff communicated with people in a meaningful way and offered reassurance and comfort, other staff did not. Some staff tended to perform physical tasks safely as required but interacted with each other rather than with the people they were caring for and we did not always see staff explaining what they were doing when moving people or checking that they were comfortable. Some of the care staff displayed no warmth towards the people using the service and did not attempt to smile, engage them in conversation or make eye contact with them.

Many people remained in their rooms, often in bed and isolated or with the door shut. We saw no evidence of staff spending time talking to people in their rooms unless they were performing a practical task. Although care plans often documented a preference to remain in their rooms there was no evidence of any encouragement or interaction from staff even when this was specified in the care plan to avoid social isolation.

People were sometimes left for long periods in communal areas without any staff present. In one lounge the television was tuned to a music video channel that was not appropriate for the residents there who were not watching or listening to it. We did not see staff offering people a choice of radio or television, or a quiet environment instead.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were two activities coordinators employed at the home and one vacant full-time post was being recruited for at the time of the inspection. There was a programme of activities for each week and this was displayed on the wall in the reception area on the ground floor. Activities were reasonably varied and catered for people’s different needs, including bingo or ball and balloon activities. We saw that there had been entertainments since the previous inspection, such as a bonfire night, opera performance, fundraising events to raise money for a garden project and musical shows.

We spoke to one activities coordinator who told us that activities were organised on the ground floor where there was a room for this purpose, in the communal lounges and in individual people’s rooms if they did not wish to participate in group sessions. We did not see any evidence of engagement in one to one activities in the daily records. There was documentation of participation in activities for one fairly mobile resident whose records we viewed. The activities coordinator we spoke with also helped out on reception and helped with personal care and serving food on occasion so was not available to support activities all the time.

A hairdresser attended the home twice a week and people could book appointments in their rooms or in the hairdressing salon on the ground floor if they wished. There were regular visits from representatives from the local Church of England and the Roman Catholic Church. The registered manager told us that staff supported people if they wished to contact other spiritual representatives and the service could provide a private room for meetings, if required.

We observed that people’s privacy and dignity was respected and staff ensured that bedroom and bathroom doors were closed when delivering personal care.

Staff described the methods they used to ensure that they respected people’s privacy and dignity such as offering choice before delivering personal care, explaining what they were doing before helping people and making sure that they were covered as much as possible when assisting with washing and dressing.

We spoke with the family of a person who had received palliative care. They told us, “We are very happy and

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Is the service caring?

grateful [our family member] came here. We are very pleased with the care [he/she] received. Staff knew how to provide care and we were consulted about the palliative care plan."

The visiting palliative clinical nurse specialist told us there were no concerns about how the service supported people with palliative care needs.

At the time of the inspection, three people had Advanced Care Plans (ACP) completed, although one person who was identified as end of life care had an empty ACP in file. We saw that anticipatory prescribing had been carried out for people with palliative care needs, which meant that a doctor had written them up for pain relief and other medicines that would make them comfortable as their condition deteriorated.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed and individualised care plans were recorded on a central electronic system with a consistent format that was easy to navigate. This system had a comprehensive assessment of each person's needs which took account of physical, medical and social needs and documented routines, preferences and wishes. It included a record of personal information such as religion, ethnicity, expression of sexuality, and end of life wishes where relevant. People were asked if they wished to receive personal care from staff of their own gender.

There was a delivery plan for each aspect of care and a monthly evaluation review and these were all up to date on the day of our visit. There were preferences and routines recorded in the plans we looked at, including bed time routines, such as preferred time of going to bed and rising, whether to leave lights on and whether to give drinks at bedtime. All elements of the electronic care files we viewed were fully completed and contained a suitable level of detail. Monthly evaluation sheets were contained in all care plans and these had been updated on a regular basis by nursing staff.

Daily records of care were also stored in this system and were completed by care staff to document the delivery of care. These were all up to date but tended to focus on physical care needs rather than recording any interaction with staff or social activities, especially for people who had been identified in their care assessments as being at risk of isolation or reluctant to engage with others.

There were profiles about 'what is important to me', 'what people like and admire about me' and how best to support me'. Although these profiles had been completed for all the care plans we looked at, the detail was sketchy and limited to one or two sentences. There was no information about people's previous life history or background. We saw that there were social and life history documents in some people's written files, but this was not clearly referenced on the electronic system.

Nursing staff had responsibility for updating care plans and monthly evaluations, while care staff maintained daily records of care. Staff said they read the care plans and were familiar with people's care needs. However, when questioned some care staff were unable to provide any detailed information about people's background or history, or how to provide meaningful psychological or emotional support to people.

For example we were told that some people didn't like to leave their rooms or participate in any group activity but there was little awareness of the direction in the care plan to address these aspects of care. None of the care staff we spoke with were able to describe the one page profile in the care file for any of the people on their unit.

We checked the records of 20 people and saw that there were 18 Do Not Attempt Resuscitation (DNAR) charts in place. These had been completed with the reason for the decision and showed that discussions with people and their relatives had taken place, as appropriate. All were signed by GP and had been completed in 2014.

We looked at how the service responded to the needs of people who had pressure sores or were identified as being at risk of pressure ulcers. The clinical lead told us that staff recorded which dressings needed to be done on white boards in unit offices. This meant that staff had a visible prompt to assist them to plan their daily schedules. However, on Balmoral unit the white board was empty and the unit manager stated it had been wiped two days before. Staff could check for this information by looking at people's care plans.

From the four wound care records we checked, three pressure ulcers occurred whilst people were living at the service. There were two systems in operation, paper records (a wound care folder) and electronic care plans. We observed that there were sometimes omissions in the care plans. For example, the measurement of wounds was not always recorded, the frequency of dressing changes were not occurring according to care plans and the type of dressing used was not recorded in three care plans.

The clinical lead told us that the service had not been able to make referrals to the community tissue viability service for several months due to a lack of funding/commissioning issue. Tissue viability training took place as planned during the inspection. Staff nurses told us they ordinarily sought guidance about pressure ulcer care from the clinical lead.

We saw that re-positioning charts were being used to document how frequently people were supported to change their position. Re-positioning is a way of minimising the risk of people developing pressure sores as it reduces

Requires Improvement

Is the service responsive?

the length of time parts of the body are exposed to pressure. We noted that there were omissions with the completion of some of the re-positioning charts. We found that the section of the form for staff nurses to sign had not been completed. This was discussed with the clinical lead who told us that registered nurses should be signing the form each day to demonstrate they had checked that the re-positioning was in accordance to people's care plans. One person's chart recorded their position as having been on their back for 48 hours.

We spoke with people and their relatives in regard to whether they had been given information about how to make a complaint and if they felt complaints would be properly responded to.

One person using the service told us, “I say what I think and so does my [family member]. I have never complained and I know how to make a complaint” and another person said, “I would speak with the deputy manager. He’s got things sorted out before.” Comments from relatives included, “I am confident to make complaints and feel they would be listened to” and “When I make a complaint they do not do anything.”

We saw a copy of the complaints procedure which was outlined in a service user booklet which was kept in each person’s room. The procedure was also on display in the reception area. The procedure contained clear timelines for response to complaints and relevant contact points within the service and outside including the local ombudsman and the Care Quality Commission (CQC).

There was also a section in each person’s electronic care record for reporting complaints although none of the records we saw had had any complaints documented.

We checked the concerns, complaints and compliments file in the office. There were five separate concerns and complaints documented from June 2014. We were not able to view the analysis report for complaints in 2014 as it had been archived; however, the registered manager was able to explain actions that the provider had taken in order to learn from complaints. We looked at two complaints received in 2015. The complaints had been investigated with follow up actions evidenced, signed and dated by the registered manager.

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Our findings

People using the service and their relatives were predominantly positive about how the service was being managed. One person using the service told us, "I think this place is well led" and a relative said, "I speak with the manager. She is very nice and talks to me regularly." Other comments from relatives included, "They ask for feedback. The manager is perfectly nice to me but it is all about budgets. I like the deputy manager, he is good", "We absolutely like the manager and how she manages here" and "I can talk to the manager but she says that nothing can be done (about staffing levels). This is not good enough."

We received mixed comments from staff about how the service was managed. We were told by some staff that they had complained about the conduct of another member of staff and appropriate action was taken. Some staff told us they had raised concerns with the management about the poor conduct of some colleagues on night shifts. They were positive about the management team responding to their concerns and carrying out a night-time unannounced monitoring visit, which resulted in disciplinary action for any staff not working in accordance with the provider's policies and procedures. Monitoring visits by the area manager were carried out during the day time as well.

We received some comments that staff did not feel consulted about changes at the service and some staff said they did not feel respected. We were told that there had not been a general staff meeting since May 2014, which was confirmed by the registered manager. At the time of this inspection we saw that a meeting had been arranged for March 2015 and staff had been invited, and a separate meeting for night staff had taken place. Some staff told us they were concerned about low morale due to factors including short staffing, management practices, lack of resources and equipment, and differences in pay.

We were told that there had not been a general staff meeting since May 2014, which was confirmed by the registered manager. At the time of this inspection we saw that a meeting had been arranged for March 2015 and staff had been invited, and a separate meeting for night staff had taken place. Some staff told us they were concerned about low morale due to factors including short staffing, management practices, lack of resources and equipment, and differences in pay. Some staff told us they were concerned because they thought staff nurses were carrying out pre-admission assessments for prospective residents without appropriate training. However, the registered manager told us that either herself or the clinical lead conducted these assessments, staff nurses shadowed as part of their training and development and the pre-admission assessments were signed off by the registered manager or the clinical lead.

The registered manager and the area manager confirmed that there was a difference in terms and conditions for staff, depending on when they joined the company. The area manager told us they did not know how the provider could address this issue but the views of staff were known. We were informed that staff representatives from the service were due to attend a national Care UK conference soon after the inspection, and the difference in terms and conditions was an item on the agenda.

There was an on-call system for staff to contact a member of the management team, if the registered manager, deputy manager or clinical lead was not on duty at the premises. We received comments from some staff that they did not know who to contact if they had a clinical enquiry and the deputy manager was on-call, as he was not clinically qualified. The registered manager told us that the deputy manager referred any clinical enquiries to herself or the lead nurse. We were informed that this protocol had been verbally explained to staff and was recorded in the service's on-call procedure, which was available for staff to read.

Meetings for people and their relatives were held at the service but were not well attended. The minutes indicated that people's views were listened to and used to improve the service, which was particularly evident in how the provider had addressed previous concerns about the quality of the food. We looked at the results of the most recent relative satisfaction survey conducted by the provider in 2014. It showed that although there were many positive comments and findings, the provider concluded that improvements needed to be achieved in order to meet its' own national standards.

There was a programme of audits planned for the current year but we were unable to view audits from previous years as they had been archived. We looked at audits carried out from January to June 2014 at the previous inspection, which were satisfactorily carried out. A health and safety audit had been completed in January and a medicines

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audit took place in February. Both audits were well documented with suitable checks. Other audits were planned for the year, which included nutrition, tissue viability, and staff supervision and support.

We reviewed systems and records for reporting accidents and incidents at the service. There was a record of accidents and incidents for each person recorded in their electronic care file. We checked a selection of these and they had been completed correctly, including a record of the date and nature of incident with any action or follow up required, and whether the GP or an external healthcare professional had been notified and/or asked for their input. A central log of accidents and incidents was generated by the system each month, showing a list of all incidents with the names of people, date and nature of each incident and whether it had been reported to other bodies such as the Care Quality Commission (CQC). We saw the list for the previous three months. Although there was a summary sheet for comments no analysis had been done so far, which meant the provider was not demonstrating that they were checking for any trends that could be addressed.

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 10 HSCA (RA) Regulations 2014 Dignity and respect **People must be treated by staff in a caring and compassionate way at all times.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There should be sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet people's needs.**