

Four Seasons (Evedale) Limited

Evedale Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This inspection was carried out on 25 & 30 May 2017 and was unannounced.

At our last comprehensive inspection of this service on 21 June 2016, we found the provider had not met all of their legal requirements and were in breach of the regulations. This was because people did not always adequately receive support with food and fluids to maintain their health and well-being. After the inspection, the provider wrote to us to say what they would do to meet their legal requirements in relation to the breach. During this inspection visit we found the provider had not made the improvements required, people were not always given the support they required to eat and drink. We found there continued to be a breach of the regulation in relation to this.

Evedale Care Home provides accommodation for up to 64 older people and people with dementia who require support with their nursing and personal care. There were 58 people living at the home at the time of our inspection. The home consists of two floors, the ground floor supports people with general nursing needs and the first floor is the Dementia Unit.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Since our last inspection the registered manager and deputy manager had left their employment at the service. There had also been three different regional managers appointed by the provider during this time. This meant the home had not had consistent managerial oversight. Continued changes in management had affected staff confidence and staff morale. People and relatives also told us they found this unsettling. At the time of this inspection a temporary manager from the provider's resident experience team (RET) was overseeing the day to day running of the home whilst a new manager was recruited.

Staff felt unsupported by the provider and did not feel valued or listened to. Constant managerial changes had affected the organisation and smooth running of the home and the provider was working hard to address this.

There were processes to monitor the quality and safety of the service provided and to understand the experiences of people who lived at the home; however the provider acknowledged that these had not been maintained. The accuracy of some audits carried out since our last inspection visit in June 2016 could not be assured and the provider was taking robust action to ensure systems and processes were used effectively to assess the quality of the service people received.

The provider's managing director and management team acknowledged the challenges the home had been through and that improvements were still required. They were taking positive steps to address the issues we

identified and to provide support to staff to ensure stability for the home.

The provider had relied on high levels of agency (temporary) staff to support staffing numbers as several permanent staff had also left their employment at the service. This meant people did not receive consistent support from staff who they were familiar with, and who knew how people liked to receive their care. Some people and their relatives told us at times staff were not always available when people needed them.

The provider had also increased the number of staff on duty to support people's needs; however this created pressure on permanent staff to support agency workers who were not familiar with the home and people's needs.

At our last inspection in June 2016 the provider told us they were making improvements to the environment on the Dementia Unit to make it more 'dementia friendly' and additional training was being provided to staff on the unit. We saw refurbishment was taking place, however staff had not yet received the additional training to support them provide specialised dementia care.

People and their relatives told us most staff were kind and considerate, and they felt people who lived at the home were safe. Staff were caring, but did not have time to interact with people unless they were providing personal care, and people on the Dementia Unit were left for long periods with little interaction. There were delays in attending to the personal care needs of some people in the home.

Staff had a good understanding of people's needs and most supported people with respect. Most people told us staff ensured their dignity was maintained at all times.

There were systems and processes in place to protect people from the risk of harm, however these were not consistently followed and some incidents had not been thoroughly investigated or reported to the local safeguarding team. Most staff understood their responsibility to safeguard people from harm. Where risks associated with people's health and wellbeing had been identified, there were plans to manage those risks. Staff were knowledgeable about risks and how to support people safely.

People mostly received their medicines at times when they needed them. We found medicines were administered, stored and disposed of correctly, however we identified some gaps on people's medication administration records (MARS). The provider had identified these issues and had taken positive steps to address them. Some people required their medicines "as required" (or PRN) and we saw protocols were available in people's medicine plans. Care records showed that people's pain levels were formally being monitored and assessed.

Some people were not involved in decisions about their care but most told us they received support in the ways they preferred. People looked well presented with clean clothes and overall people's privacy and dignity was promoted, but sometimes this was compromised by having to wait for staff to support them to use the bathroom. People were supported to maintain relationships with people important to them and visitors were welcomed at the home

Staff did not consistently receive support from the provider to enable them to provide effective care to people. The provider acknowledged that training requirements had not been maintained, however this had been identified and improvements were underway to ensure all staff received their required training.

Staff understood the principles of the Mental Capacity Act (MCA), and most gained people's consent before they provided personal care. People told us they were encouraged to make choices about their daily lives.

There were policies and procedures in place to ensure that people who could not make decisions were protected, and we found assessments had been completed.

Most people were supported to eat and drink by staff; however on the Dementia Unit some people who required support did not consistently receive it. This had been identified at our last inspection visit in June 2016 and the provider had failed to make improvements. We saw people on the ground floor received a good choice of food and drink, and people's individual food requirements were catered for. However some people on the Dementia Unit were not given choice with their food and drink.

Overall, people's health needs were met. We saw appropriate referrals were made to specialist healthcare professionals where people needed support, for example with eating and drinking and skin care.

Care plans and assessments contained information that supported staff to meet people's needs. However some lacked detail and were not 'person centred' in relation to how people liked to receive their care. People and their relatives were not consistently involved in the planning of care. The provider was addressing this with further training for staff and new documentation was being introduced.

The provider employed activity workers to support people with their activities, hobbies and interests. Relatives had previously expressed concerns regarding the lack of activities on the Dementia Unit and the provider was addressing this, however we still found improvements were required.

We found three breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People and relatives told us there were not always enough staff available at times people needed them. People did not always receive care and treatment that met their individual needs and ensured their safety and welfare. Most staff understood what action to take if they had any safeguarding concerns. Incidents and accidents were not always thoroughly investigated. People did not consistently receive their medicines as prescribed. Risk assessments were mostly completed and staff were knowledgeable about people's risks and how to support them. Staff were recruited safely.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Most people were supported to have a nutritious diet, however some on the Dementia Unit did not receive enough support to eat and drink, or choice of meal. Staff were aware of their responsibilities regarding the Mental Capacity Act and Deprivation of Liberty safeguards. Staff received some essential training to carry out their role but had not received training to provide specialist dementia care and not all staff training was up to date. People were referred to other health professionals when further support was required.

Requires Improvement ●

Is the service caring?

The service was not always caring.

People's dignity was mostly respected, but sometimes this was compromised by having to wait for staff to support them to use the bathroom. Staff did not always knock on people's bedroom doors when entering their room, but ensured people's privacy when undertaking personal care. People thought staff were kind and caring, but most engagement with people was task led when personal care was being delivered.

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People did not always receive care which was responsive to their needs. Some people's interests were supported by activity workers however their work was sometimes compromised by being involved in other tasks around the home instead of activities. People felt able to complain, but some did not know what the procedure was. Complaints were recorded but some relatives were unhappy with the response received.

Is the service well-led?

The service was not well led.

The home had undergone several management changes and there was inconsistent managerial oversight. The provider and management had not ensured systems in place to monitor the quality and safety of service were consistently completed or accurate. Staff had not consistently felt supported by the provider and did not feel valued or listened to. The provider was actively addressing issues.

Inadequate ●

Evedale 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 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 25 and 30 May 2017. It was unannounced on the 25 May 2017, but the provider was aware we would be returning on 30 May to complete our inspection.

Three inspectors, an expert by experience and a specialist advisor conducted the inspection. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in nursing care. An expert-by-experience is someone who has knowledge and experience of using, or caring for someone, who uses this type of service.

Before the inspection we looked at the information received from our 'Share Your Experience' web forms, and notifications received from the provider. These are notifications the provider must send to us which inform of deaths in the home, and incidents that affect people's health, safety and welfare. We also contacted the local authority commissioners to find out their views of the service provided; they had identified areas of concerns and were closely monitoring the service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to review the information in the PIR during our inspection. We found it did not always reflect the service we found.

We talked to seven people who used the service and seven relatives. We spoke with 13 staff. This included nurses, care staff, the maintenance worker, the chef, and the activities coordinator. We also spoke with five other Four Seasons staff and managers who had been working with the home to support improvements. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We observed care and support provided in communal areas and we observed how people were supported to eat and drink. We looked at a range of records about people's care including seven care files, daily records for personal care, and fluid and food records charts. We also looked at 20 medicine administration records (MARS).

Is the service safe?

Our findings

At our last inspection in June 2016 we found the provider had not reported a safeguarding concern to the local safeguarding team. The provider informed us they would support the registered manager and staff to ensure they were aware of their responsibilities to report concerns to the appropriate authorities.

Prior to this inspection visit we received information from the provider that correct procedures still had not been followed relating to safeguarding incidents. Although initial actions had been taken to keep people safe, some investigation findings were not fully documented and some referrals had not been made to the local safeguarding team. This is important as the local safeguarding team may need to carry out further investigations to ensure the provider had taken appropriate actions to keep people safe.

We discussed this with the provider during our inspection visit and the interim manager told us, "When I came here I discovered safeguarding's were not always correctly reported." A routine audit by the provider had highlighted the issues. As a result the provider had carried out a review of all incidents and accidents, and those requiring further investigation were identified with action points to ensure investigations were completed and relevant referrals submitted.

We had mixed responses from people and their relatives when we asked if they felt safe. One person told us, "Some staff were a bit rough when they are handling me. I complained once about the staff and they [manager] dealt with it." We discussed this with the provider during our inspection visit and they told us moving and handling training updates were planned for staff shortly after our inspection visit. They also told us they would speak to the person to make sure there were no new concerns.

One relative told us their relation was frightened when staff they were unfamiliar with, entered their room without speaking, which caused them anxiety. They went on to say they had complained to a member of the management team who advised them they would investigate this. Another relation told us changes in staff caused their relation anxiety, "There seems to have been a major disruption here, I see people [staff] leaving all the time which doesn't help dementia care, which is helped by familiarity."

However some people we spoke told us they did feel safe, comments made were, "The atmosphere is fine here. Oh God yes, quite safe, no trouble at all. If there was I would speak to the nurses." And, "Yes I feel safe, they [staff] move me safely and I have my call bell if I need them."

Staff we spoke with understood their responsibilities for keeping people safe and demonstrated their awareness of what constituted abuse or poor practice. One said, "Abuse could be shouting, or swearing." Another said, "Abuse could be any kind of harm." Staff told us they had completed training in safeguarding and knew what they should do if they had any concerns about people's safety or if they suspected abuse. Staff confirmed they understood the importance of reporting concerns to a senior member of staff.

There was a procedure to identify and manage risks associated with people's care. People's care needs had been assessed to determine if there were any potential risks to providing their care and support. For

example, moving people safely and reducing the risk of their skin becoming sore from prolonged periods of immobility. However, risk assessments did not consistently provide sufficient information for staff to reduce known risks.

For example, we looked at one person's records that contained information about a person's risk of choking when they were eating or drinking. The risk assessment and care plan advised staff to look out for signs of choking but there was no guidance to inform them of what action to take should the person start to choke. This would be important information especially for staff who may be new to the home, or agency workers unfamiliar with the person. Whilst the records did not give sufficient detail about staff response to choking, we saw staff support the person safely during their meal time.

We observed one person in the Dementia Unit who began to cough whilst staff supported them with a drink and they continued to each time they took a sip. This might have indicated they were experiencing problems swallowing. There was nothing documented in the person's care records that identified they were at risk of coughing or choking. We discussed this with the acting deputy manager, who told us they were unaware of this potential risk as staff had not informed them. They advised us the person's health had recently declined and they would observe them further and make a referral to the speech and language therapist for further support.

One person did not have access to a call bell. Care staff told us, and the daily notes confirmed, that the person was at risk of placing the call bell wire around their neck, although there was no risk assessment in place confirming this. We were concerned that the person was not able to call for assistance when required. However we were informed by the deputy manager that the person was checked regularly by staff. The regional manager informed us wireless call bells would be ordered for people identified as at risk. We were also told the person's individual risk assessment would be completed by the end of our visit.

We asked people and relatives if they felt there were enough staff to provide care and support. Some people we spoke to told us staff were not always available at times they needed them. Comments made were, "Sometimes I have to wait, they are short staffed." One person told us, "The main thing is they don't have enough staff, I have my call bell but sometimes I wait for up to 15 minutes. They just can't keep their staff." However other people told us, "They come quite quickly when I use my bell." And, "I rang my bell this morning, they came in around five minutes, I never have to wait long when I ring."

Some staff we spoke with felt at times there were not enough of them to keep people safe and they felt under pressure; comments made were, "I can't be in two places at once, I try my best but there just isn't enough of us to provide anything other than basic care." Others told us due to work load pressures they worried they would be unable to answer call bells in a timely manner which could place people at risk.

Six months before this inspection visit the provider agreed a contract with the Clinical Commissioning Group (CCG) to provide 20 beds for people who had been in hospital and required further nursing care and support before going back to their homes. People using the contracted beds stayed at Evedale for a period of between six to 12 weeks. The provider acknowledged this had created additional pressure for staff and decided to stop admitting people to ease this pressure, because they could see staff were not coping well.

The provider had identified there were insufficient numbers of staff to support people's needs and prior to our inspection visit had increased staffing levels. One member of staff told us, "Three weeks ago we had a staff meeting and they increased us from five [staff] to six in the mornings. That is not always the case." Several staff we spoke with told us they felt people were safe because staffing numbers had increased. One member of staff told us, "There is a big, big improvement." A relative we spoke with told us they had

previously been concerned about staffing levels. They said they had visited the home on one occasion and found a person had fallen in the lounge, they had to summon staff to help the person. They went on to tell us, "Over the last few weeks a lot has changed. The staff are happier, the place is cleaner, and it's a much better atmosphere now."

The provider told us to maintain staffing levels they were employing high numbers of agency staff which meant people did not always receive care from staff that knew them well. Some people told us they found this unsettling, comments made were, "Agency staff don't know me or understand me." And, "Sometimes the agency staff don't always know what they are doing." The provider's management team acknowledged the recruitment and retention of permanent nursing and care staff had been their biggest challenge. To ensure continuity of care, they told us they tried to request agency staff who were familiar with the home and the people who lived there.

We looked at how medicines were managed by the service. We had been informed by the provider prior to our inspection visit, that there had been problems maintaining correct stock levels of some people's medicines. This meant some people were unable to receive their medicine as it had not been delivered to the home. This is important in order to maintain people's health and well-being.

We looked at three people's MAR charts and saw there had been recent gaps in them receiving their medicines. Records showed this was because their medicines had not been delivered in time to replenish the stock. One person did not receive their medicines to maintain their iron levels for five days and another, who required their medicine to maintain their mental health, did not receive it for seven days. The third person required their medicine to reduce their cholesterol; they did not receive it for two days.

The provider's pharmacy technician told us this was due to issues with the supplier and the provider had met with them to address the concerns. They went on to tell us they now had more robust auditing of medicines and their ordering process had been updated. They had also introduced a new training programme, the aim of which was to examine medicine errors that had occurred within the provider's homes and for staff to examine them and discuss how they could be prevented from reoccurring.

Prior to our inspection visit the provider contacted us to inform us that a person's pain had not been correctly assessed and guidance given by the doctor had not been followed. The provider had taken action to address this. The provider's pharmacy technician told us they were actively working on a process to improve the management of people's pain. During our visit we saw people's pain levels were now formally assessed to ensure their medicines were effective and they were comfortable and pain free.

Overall, we found medicines were stored and administered safely. We saw people's medicines being administered in their rooms. The nurse knocked the door before entering and introduced herself and enquired as to the person's well-being. People were appropriately supported to sit up before taking their medicines and explanations given before the medicines were administered.

We checked several medicine administration records and found these were completed correctly. However some did not have a photograph of the person, this is important as staff unfamiliar with the person would not necessarily be able to confirm their identity if the person was unable to tell them. Some medicines required careful storage and monitoring due to their strength and their stock levels needed to be checked daily, we found these checks had been completed.

Some people had medicines prescribed on an 'as required' basis (PRN), for example, pain relief drugs. When these were administered the reason why the person received the medicine, and its effectiveness in reducing

pain was recorded. We saw protocols (medicine plans) for the administration of these medicines were in place and these gave staff comprehensive information about when, and why, they should be administered.

Nursing staff had their competency to administer medicines checked to ensure people received their medicines safely. The nurses we spoke with told us they had attended medicines management and administration training, when they started working at the service and they attended regular training updates.

Incidents and accidents were not consistently monitored by the provider to reduce the likelihood of them happening again. This had been identified by the provider during an audit and the regional manager told us they would personally be analysing the information to ensure this was being carried out. The service had introduced a 'Vulnerable Resident List'. This provided the manager with up to date information about the risks related to people who lived in the home, so they could monitor and ensure staff were working to minimise such risks. These included risks associated with nutrition, falls, mental capacity and skin integrity.

The provider had recruitment procedures to ensure staff who worked at Evedale were of a suitable character to work with people who lived there. Staff told us their Disclosure and Barring Service (DBS) checks and references had been checked by the provider before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services. Records confirmed the required checks had been made before staff started working in the home.

We checked the premises were being maintained and health and safety checks were in place. The provider's records did not document maintenance checks carried out for two individual months at the beginning of the year due to the absence of the maintenance worker. These included monitoring of water temperatures, fire doors and fire alarm checks. We discussed this with the managing director who assured us the provider's health and safety team had carried out the work but had been unable to record their actions as they were unable to find the files which contained the records.

We saw people had emergency evacuation plans, however the file which the emergency services would access was inaccurate. This is important in order for emergency workers to know how many people were in the building and their individual needs. The provider's administrator told us this would be rectified.

Is

Is the service effective?

Our findings

At our last inspection in June 2016 we found the provider in breach of the regulations as some people did not receive enough support to eat and drink. We found the provider had not made improvements and was still in breach of the regulations.

On the first day of our inspection we observed the lunchtime experience for people on the Dementia Unit. We saw people had to wait for considerable periods of time whilst staff were either serving meals to other people sat on their table, or taking meals to people who ate their meals in bed. For example, 10 people were sat waiting for their meal at 12.49pm, and 40 minutes later four people were still waiting for their meals having sat watching others eating in front of them.

Some people required their drinks to be served in special beakers with lids on to make drinking easier for them. We heard a member of agency staff say there were no more beaker cup lids available. This meant those people, who needed fluids via a beaker, could not have them at the times they chose. On the day of our first visit the temperature outside was 28 degrees.

On the second day of our inspection visit we saw one person in their bedroom at 1.10pm struggling to eat their food alone. We did not see what time they were given their meal. At 1.20pm a care worker came in and told us the person was usually independent and they would wait to see if the person required additional support. The member of staff eventually supported the person; however their food would have been cold by this time. We checked the person's care plan and saw it had recently been revised and informed staff they now needed to actively support the person to eat their meals. We asked staff if they had time to read care plans, and they told us they did not. They said they were informed of any updated information about people and their needs from various sources such as their colleagues, handover meetings, the person or their family.

During the lunchtime experience we observed a lack of interaction by staff with people. Most communication was confined to encouraging people to eat their food and we heard one member of staff tell a person, "Eat your dinner." in an uncaring manner. The person needed more support than they initially received from staff to have their meal. We did not see people being offered a choice of their meal, and staff made the choice for them.

This was a continued breach of Regulation 14 HSCA RA Regulations 2014.

We discussed our findings with the managing director who acknowledged that improvements had not been made since our last inspection in June 2016. They told us this was a priority area for the service to improve on. They had discussed this at a recent staff meeting and told us the dining experience for people had not been correctly audited by the management team. They told us a dining audit and a 'dignity in dining' audit would be completed at each meal service and action taken accordingly to address any areas of concerns. They told us they were committed to improving the support offered to people and to improve the meal time experience.

Some people we spoke to were happy with the food provided and told us they were offered choice. One person told us, "The food here is good." One relative commented, "[Person] gets support to eat, the food seems alright." and another told us, "I haven't seen meal choices offered, I've seen support eating, no issues with that."

Staff had a good understanding of people's specific dietary needs and people's dietary choices or needs were catered for at the home. However one staff member told us they were concerned that agency staff would not have that knowledge about people.

We spoke with the chef who told us they were provided with information about people's individual dietary needs and preferences. This information was often given to them verbally, however the provider had recently re introduced notification sheets regarding peoples specific dietary needs, such as pureed meals for people at risk of choking. The chef used this information to prepare specific meals for people, for example people who had allergies to certain food, or required high calorie meals to help maintain their health and well-being.

The chef told us the menu was not chosen by people who lived at the home however a letter was due to be sent out asking for people and their relatives feedback on what they would like to see included. Where people had dietary requirements because of their religion or allergies the chef was aware of this. One person did not eat beef and we saw they were provided with an alternative at lunchtime.

Prior to our inspection visit we were made aware by the provider that an internal audit had noted two people, who had been identified as losing weight, had not been referred to the appropriate healthcare professionals for support. The provider took immediate action and referrals were made to the dietician and speech and language therapist. Following this, staff were spoken to individually to remind them of their responsibility to monitor people's weights and report concerns to the appropriate professionals. Weights were also recorded on a computer tracking system, which alerted staff if people had lost weight, and the 'Vulnerable Resident List', so that timely action could be taken. People were weighed regularly and where they had been assessed as requiring extra support to maintain a healthy weight, referrals to the dietician had been made.

Fortified food, such as full fat food products and regular snacks were given. One person we spoke with required high calorie drinks and we saw these were on their table and in reach for them.

Staff told us they completed an induction when they started working in the home and had training to refresh their skills. The provider had enrolled staff on the Care Certificate which provides care staff with the fundamental skills they need to provide quality care.

At our last visit in June 2016 the provider told us some staff had not received all training the provider considered essential to meet people's health and social care needs. At this inspection visit the new regional manager told us the majority of training provided was through e-learning modules and they felt 'face to face' was a more effective method as it gave staff practical opportunities to learn and ask questions. Recent staff training compliance had increased in the month before our visit from 40% to 73%.

At our last inspection in June 2016 we were concerned that some staff did not have specialist training to support people who lived with dementia. The provider had identified that further training was required and was looking to implement the 'Dementia Care Framework' at the home. This would equip staff with skills to provide personalised care for those people who lived with dementia. The regional manager confirmed this had not yet been implemented but plans were in place for the programme to shortly after our visit. We saw

staff had a basic understanding of engagement with people who had dementia. They understood behaviours and how to manage them, but the focus was on keeping people safe. Staff did not appear to know how to support people who lived with dementia to have a better quality of life.

Staff told us about the training they had received to help them to carry out their roles. One said, "Hoist training was good, it made me feel confident that I know what to do." Another said, "We have some online learning, I do it at my pace." They explained this helped them to learn and improve their knowledge and confirmed they were allowed time to complete the training.

We saw staff put their training into practice. We observed staff use a hoist to safely move people on four occasions. Each time staff explained to the person what they were doing. They reminded one person to keep their head back so they did not catch their face on the hoist.

One member of staff told us they had received training in how to treat people with dignity. They told us this had helped them 'open their eyes'. They told us before they had received this training they were 'guilty of mothering people' and they now realised the importance of treating people as adults with the dignity they deserved.

We asked people if they felt staff had the skills and knowledge to support them safely. One told us, "They move me well; they have obviously been well trained." A relative we spoke with told us, "I haven't seen anyone who isn't capable."

One person we spoke with told us on one occasion they had begun to choke on their food and the managing director, who was present at the time, had come to their assistance. They told us, "That manager saved me; she knew exactly what to do."

One nurse we spoke with told us they had undertaken specialist training and an additional qualification in supporting people who were near the end of their life. This meant they could train and share their knowledge with other staff when this specialist care was required. The provider informed us a new programme of training was also underway to support nurses with meeting the requirements of their registration and on-going learning needs. They told us, "We want to retain our nursing staff...we need to make them feel engaged and valued."

Since our last visit in June 2016, staff had not received regular individual meetings with their line manager to discuss their work. The provider was aware of this and staff confirmed the week before our visit they had started to receive this additional support.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The management team understood the relevant requirements of the Mental Capacity Act (MCA) 2005. We saw that mental capacity assessments had been undertaken and these determined whether people could make informed decisions about various aspects of their lives. Care plans contained information as to whether people had capacity to make certain decisions, and if not, what decisions they needed support with or should be made on their behalf in their 'best interests'.

Staff had an understanding of the principles of the Act and how this affected their practice. Staff understood the importance of obtaining people's consent prior to providing care and support. A staff member told us, "MCA is about decisions and making decisions in people's best interests if they no longer can." "We can't presume someone does not have capacity."

Staff knew they had to gain consent before they provided care to people. Comments included, "I always ask if I can offer a bit of help. If someone says no, that is fine." And, "I cannot force anyone to do anything they don't want to."

We asked people if staff asked for their consent before providing their care and we received mixed views. One commented, "They just walk in usually, never knock or ask if it's ok." And, "They just do it, they don't ask my permission." However others we spoke with told us staff asked for consent, comments made were, "Yes, they always ask my consent," and, "I don't like the hoist, when I say I don't want to go on it, they respect that it's my choice."

We asked people if they received health and social care when required. One person told us, "The doctor comes. I have a chiropodist, and I have seen an optician." Another person told us, "They organised the doctor quickly for me the other day." And, "They are really good at getting a doctor if I need one." However one relative we spoke to told us there had been a lack of organisation by the home when their relation needed an appointment for a blood test before they were able to have a medical investigation. They commented, "In the end I had to organise this myself before it could be done."

From care records we saw that staff followed instructions given to them by health professionals to make sure people received the necessary support to manage their health and well-being.

Is the service caring?

Our findings

Most people and their relatives felt staff were caring. One person told us, "Some of the staff are lovely." Another told us, "I think the care is good, they do very well." However one commented, "[Person] has good care, but some staff are better than others."

We saw most staff tried to be caring but they were very busy. We overheard friendly conversations between people and the staff. One person commented to us, "She's [staff member] a good one she is, looks after me."

Most staff interacted positively with people when they undertook care tasks, however they did not have much opportunity to interact with them at other times. People we spoke with confirmed this, one told us, "They just don't have time to talk." And, "Some staff will talk to me but their time is very short." One staff member we spoke with told us they would like to have more time to sit with people who were unwell and hold their hand.

We spent time in the communal areas of home and overheard laughter during a painting session in the lounge. We saw most staff treated people with kindness. For example, staff sat down on the floor next to one person because this made it easier for the person to have a conversation with them. This approach worked well as the person and the staff member chatted for several minutes about the nice weather.

However, on the Dementia Unit we observed staff had little time to engage with people and we saw little interaction between staff and people outside of providing care and support. During our visit we sat in the lounge with people for 40 minutes. During this time we saw engagements between people and staff was limited to staff entering the lounge to give people drinks, or when people were moved into the lounge from the dining room. One staff member remained standing when they supported the person with their drink, not using this as an opportunity for engagement but a task that needed to be completed quickly. Once a task was completed there was little contact with staff, for example, we observed several staff members passing the lounge where people were sitting, but none came in to say hello or check on people's welfare.

The permanent staff told us they had built up strong and meaningful relationships with the people they cared for. This was because those we spoke with had mostly worked at the home for a long time. It was clear from our discussions with staff they showed genuine concern for people's well-being. One commented, "I treat people like my own family." Another said, "We all care about the [people] that's why we stay here."

However, when we spoke with staff they told us they did not feel the provider or management team cared or valued them. One said, "They don't really listen to us and they don't introduce themselves or even say hello to us." Another said, "Senior managers see us as numbers on the floor rather than recognising what we actually do." Some felt the low morale impacted on people living in the home.

We saw in recent staff meeting minutes that staff had expressed their views to the managing director and the acting manager told us, "We are trying to gain the staffs' confidence, we need to support them, some feel

vulnerable and many are very good."

Staff were committed to encouraging people to make choices. One said, "People making their own decisions is paramount here." Another said, "People making their own decisions keeps them independent." People we spoke with confirmed this, and told us they were supported to maintain their independence, and the support they received was flexible to their needs. One person told us, "They encourage me to be independent as I can." Another told us, "Yes they do respect me and help me to be independent, I like to shave myself." We saw staff encouraged people to be as independent as they wished to be. For example, one person was encouraged to hold the cup they were drinking out of instead of staff holding it for them, as they were able to hold it for themselves.

We saw some people were offered choices, such as where they wanted to sit, if they wanted to paint pictures and what they wanted to watch on TV. One person we spoke with told us, "I choose how I want to spend my day." However we saw people on the Dementia Unit were not offered choices with their meals, and some people sat in the same position in the room throughout the day, with the television on.

Staff told us they respected people's right to privacy. Comments included, "I always knock bedroom doors." During our inspection visit this did not always happen and one person told us, "They just walk in usually, never knock or ask if it's ok". We saw one person's care plan advised staff to close their bedroom door at certain times to ensure their privacy. Two staff members we spoke with were not aware of this. One told us, "I'll be honest; we don't get time to read care plans."

Most people we spoke with told us their dignity and privacy was respected by staff. One person told us, "They are very respectful, they never embarrass me." A relative we spoke with told us their family member had requested not to have a male care worker assist them with their personal hygiene, they told us, "[Person] definitely makes her own decisions. She won't have a man in her room when she is being washed and dressed, and they comply."

However we saw in one of the lounges in the dementia unit, one member of staff brushed two people's hair and applied lipstick. The staff member had good intentions in doing this because they wanted the people to look nice. They told us they did not realise this compromised the person's dignity by doing this in a communal space.

Some people we spoke with told us they were not involved in making decisions about their care and had not been involved in planning their care. Several did not know what information their care plan contained. Comments made were, "I don't know what a care plan is, I've not seen that." And, "They have a care plan but I can't read it. They never discuss my care." The regional manager was made aware of this at the time of our visit and informed us the resident experience team were in the process of working to improve people's involvement in the planning of their care.

People were encouraged to maintain relationships important to them and visitors were welcomed at the home. A relative told us they could visit whenever they wanted to and told us, "Some of the staff are just brilliant and always speak to me." During the day we saw several visitors spent time with their friend or relative who lived at the home.

Friends and families had the choice of meeting privately with the person in their bedroom, or in the larger or smaller lounge areas situated throughout the home.

Is the service responsive?

Our findings

During our inspection visit we saw one person who was sitting in the lounge shouting out for staff as they needed assistance to get to the bathroom. Call bells were fixed to the wall and out of reach for the person to summon staff and there were no staff available in the lounge to support the person. We saw they were clearly anxious and we approached them to see if we could assist. We asked if they would like us to find a staff member to support them and they told us, "They will tell me to go in my pad." One staff member then entered the lounge and ignored the person's request and told them, "I am going on my break." They then left the room. We spoke with another member of staff to inform them the person required the toilet and the person was then assisted. We discussed this with the regional manager who informed us they had taken immediate and robust action with the member of staff involved.

At our last inspection visit in June 2016 we identified that some people's care plans did not contain sufficient detail about how the person liked to receive their care, and information was not always up to date. The regional manager told us improvements were still needed in relation to care records and this had already been identified during the provider's checks on care records and they had started to address this before our visit.

Reviews of care plans were underway and simplified care plans were being introduced for staff to be able to find relevant information more clearly. Specific hospital discharge care plans, for people admitted into the 'contract beds', were also being introduced to reduce time pressure on the nursing staff.

We found some records did not provide staff with sufficient detail about how people would like to be supported to receive their personal care. For example, one person's care plan advised staff they needed 'full assistance' to get dressed. No detail of the persons preferences were available however, staff described to us how they assisted the person in-line with their wishes and choices. Another person's records showed they had been seen by the tissue viability nurse (wound specialist). Advice had been given by the nurse that the person should be repositioned regularly to help heal their wound. The care plan did not contain sufficient detail for staff to follow, however we saw on the persons turning charts that they were being turned in accordance with the advice given and that their wound was healing.

Some care plans we looked at showed they had been reviewed recently and gave accurate information of people's needs and how staff could support them. However it was sometimes difficult to find relevant information quickly due to the large amount of paperwork contained in some.

We asked staff if they had time to read care plans and they told us they didn't. However they told us they found out about people's needs and wishes through talking directly with them or through the staff handover meeting at the beginning of their shift. One member of staff said, "Some people like things done a bit differently each day, I always check how they are feeling and how much help they need." Another told us communication provided about people at the shift handover was informative and, if they had been off for a few days, they would read back through people's daily notes to update themselves on any changes.

Each person had a care and support plan with information personal to them. Some care plans included information in relation to maintaining the person's health, their daily routines and preferences. For example, one person's care plan advised staff they did not want to be disturbed at night to receive welfare checks and to have their catheter bag emptied. The person was able to use their call bell to summon assistance from staff if they needed it. We saw that staff respected the person's wishes. Their care plan also informed staff they liked to sleep with five pillows and we saw the person had these on their bed.

We asked people if they felt staff responded to their needs in a timely manner and we received mixed views. One person told us, "No, sometimes I have to wait for my wash." And, "Sometimes I have to wait if they are busy or short staffed."

At our last inspection visit in June 2016, people and their relations had commented activities were lacking, particularly on the Dementia Unit. Although some people spoke positively about the activities coordinator some relations still expressed concerns about the lack of specific activities for people. One relative on the Dementia Unit told us, "The caring is ok, but the dementia care and stimulation is lacking here." Another relative told us, "[Person] never goes out for a walk, in fact I have never seen anyone outside; it's like a prison."

We saw some people on the dementia unit spent their days in their bedrooms with minimal engagement with staff who mainly engaged with them when care tasks were required. A member of staff told us, "These people need more activities, they need more creative staff. They need more stimulation, their quality of life is 'routine'." We spoke briefly with one of the activity coordinators. They told us they tried to provide individual activities to people as well as group activities, but told us they often supported people with their drinks and with meals which took them away from their duties. This was discussed with the senior management team who told us this would be immediately addressed.

The provider employed two activity coordinators in the home. We asked people if they were involved in activities, and had mixed responses. Some people told us they were often bored in the home with little to do. Comments made were, "They haven't discussed my interests at all. I just stay in my room, don't do any activities." And, "It gets a bit boring, staff just don't have time."

We discussed this with the regional manager who acknowledged that improvements were required. They told us they would provide training to staff to assist them to identify opportunities for positive engagement with people. An activity co-ordinator from one of the provider's nearby homes would be asked to support the activity programme and introduce specific activities for people who lived with dementia.

During our visit the activities coordinator carried out some individualised activities with people in the communal lounges. They gave people lap trays so they could paint pictures and assisted them to choose colours. They sat on the floor between people chatting and telling them how lovely their art work was. Some people we spoke with told us they were satisfied with the level of activities offered, one person told us, "I get asked to do activities; but I would rather stay in my room." Another person told us they enjoyed ball activities and felt the activity coordinator, "Explains everything well to me, she is very good."

The provider was making improvements throughout the home with new decorations, curtains and carpets and a vintage style tea room. A combined library and music room was being planned for people to meet and spend time with their family members.

People and their relatives told us they would feel able to make a complaint if necessary. Some were unsure how to make a formal complaint but felt confident to tell staff. One person said, "If I had to complain I would

tell the staff." Another told us, "I did complain once, they dealt with it." Relatives told us they were sometimes unhappy with the response taken to complaints they had made. One told us they had complained about the recent staff changes but were not fully satisfied their concerns had been addressed and described the managers as, "More like politicians."

The regional manager told us they were keen to obtain feedback from people and keep them updated on changes at the home. Residents and relatives meetings had been held and more were planned. In addition there was a 'tablet computer' available in the main foyer where visitors could register a complaint and make a request to see the manager to discuss any concerns.

Is the service well-led?

Our findings

The provider has a history of non-compliance with the regulations of the Health and Social Care Act 2008 at this service. In August 2012 we found they were non-compliant with the regulations regarding sufficient numbers of staff and the care and welfare of people who used service. We found improvements had been made on our follow up inspection in November 2012. In November 2013 we inspected the service again and found the home compliant.

In May 2014 we inspected and found the provider non-compliant with the regulations around staffing, medicines and record keeping. A follow up inspection in November 2014, (under our new rating system) found the home had not improved and was rated as 'Requires improvement' overall and inadequate for the safe care and treatment of people. The provider was again in breach of the regulations for staffing and the planning and delivery of care which supported people's individual needs. In April 2015 we carried out an inspection to see if the provider had made improvements and found they were no longer in breach and the provider had increased staffing levels to ensure people were safe.

At our inspection visit in June 2016 we found the home was not consistently well led and the provider was again in breach of the regulations in relation to the lack of adequate support some people received to eat and drink. The provider had recruited a new manager who registered with us and there was a new regional manager supporting the home. People, relatives and staff told us at the time they were starting to see improvements being made in the home.

Since our last inspection we found there continued to be inconsistent leadership at the home. The registered manager, regional area manager and the deputy manager had all left. As a result an interim manager had been overseeing the service since March 2017. There had also been two new regional area managers who had both moved onto managing other of the providers' services.

As a consequence of continual management changes, we found not all of the improvements made had been sustained and the provider was again in breach of the regulations. We found the home was not well led and the provider failed to consistently provide, and ensure, good governance. We found no improvements had been made in relation to the support people required to eat and drink. The managing director told us, "I think it's actually got worse."

The managing director and management team were open and transparent that the lack of senior managerial oversight had led to inadequate support for the previous registered manager. This had impacted on systems and processes not being fully completed and monitored, to ensure the quality of the service provided. We saw the last provider audit that was carried out two weeks before our inspection visit. This showed an overall compliance to the provider's standards of only 56 per cent. We saw a comment recorded that there were a 'large number of outstanding actions' that required completion.

As a result of concerns identified, the provider had temporarily stopped new people moving into the home and had organised for a new, experienced regional manager to oversee the service. Management

acknowledged there were limited improvements since our last inspection visit and explained some of the internal management problems they had faced. They told us the introduction of contracted beds had placed pressure on the service and it had become overwhelmed.

To assess the quality of the service the provider carried out audits that included checks on the management of medicines, care records, health and safety issues, staff training and the safety and cleanliness of the premises. The regional manager identified these had not been completed correctly and the results did not accurately reflect the service provided. They appeared to show the service was performing at a higher standard than it actually was.

We looked at incident and accident investigations and saw where issues had been identified some had not been thoroughly investigated. Actions taken were not always clearly recorded. We saw five incidents of unexplained bruising where no investigations had been completed. For example, we saw in March 2017 that one person had been reported to have bruising above their eye. We could not see any investigation had been undertaken as to the cause of the injury or if a safeguarding alert had been raised with the local authority.

This was a breach of Regulation 17 (HSCA 2008 (Regulated Activities) Regulations 2014

We had also not received statutory notifications informing us of these incidents. A statutory notification is information about important events which the provider is required to send to us by law. The provider had already identified these issues and had taken steps to ensure investigations were completed and the relevant authorities informed. However we had still not received the relevant notifications following our inspection visit.

This was a breach of Regulation 18 (2) Care Quality Commission (Registration) Regulations 2009.

Staff we spoke with told us, "I am fed up with the management changes. We get sorted and then the manager leaves. We go back to square one." Another told us, "I was here last time you came. We had improvement managers coming in. Things got better for a while and then dipped again. I felt like phoning in sick today."

All the staff we spoke with told us the constant changes in managers had led to the service being disorganised and communication amongst staff was poor. The provider conducted staff satisfaction surveys and the replies reflected what staff told us during our inspection visit. For example one question asked if, 'I trust my manager to do the best for me and the home' only 62 percent indicated they agreed in March 2017, and only 53 percent said they would recommend the home to a friend or colleague.

Staff told us they did not feel the provider's management team listened to them or valued their work and some were not confident to speak out because they were fearful of disciplinary action being taken against them. One told us, "I know some staff are unhappy and this is picked up by the [people] it's not fair on them. We have new managers and they are like a bull in a china shop. Making changes for changes sake."

We spoke to the management team about staff morale and the acting manager told us, "Lots of our staff are very caring but they need that leadership and guidance, not only from the nurses but also the managers." Prior to our inspection visit the managing director had met with staff who had the opportunity to discuss how they were feeling. We saw in the minutes they had told staff, "We should be working as a team, we are here to help you and we will do everything we can to put things right."

We asked people if they felt the home was well led and had mixed views, comments made were, "I think it's a nice home really, they are starting to improve things, but there are just so many manager changes." And, "No, I have seen the manager once ...I haven't a clue as to her name." Whilst people and staff expressed concerns over the changes in managers at the home we found some who felt improvements had recently been made. Comments made were, "I think it's gradually picking up." And, "I would rate the home eight out of ten; they just need the right manager now."

People had opportunities to share their views about the service they received and we saw overall satisfaction of the service from January to May 2017 was 80 percent and 95 percent of those questioned felt the home was 'a happy place'. One person told us, "There are residents meetings; I could go if I wanted to." We saw a meeting had been organised shortly before our inspection visit.

Staff team meetings had not been held regularly since our last inspection visits in June 2016. The managing director had recently met with staff, including a separate meeting for night staff, to discuss the recent changes that had taken place in the home. We looked at the staff meeting notes. The meeting agenda focused both on staff issues, managerial changes and how best the staff could support people who lived at the home. We saw they had discussed the importance of knocking on people's doors and the lack of personal interactions with people living at the home. We also saw the managing director had commented that they felt residents looked 'sad' and that staff as a team needed to work together to improve this.

We asked the management team how they could assure us that people and staff would be supported moving forward and effective systems and processes would be in place to monitor the quality of the service provided. The managing director and management team were open and transparent regarding the challenges the home faced. The managing director acknowledged that the home had experienced a difficult year due to the numerous managerial changes, but they were confident things would improve. They told us the lack of consistent regional manager support had impacted negatively on the service provided and staff morale.

The provider could not explain why there had been so many changes in the regional manager position which had contributed to the instability of the service, however they told us they were committed to ensuring stability for the home and were confident the new regional manager would be fully supported in their new role.

An experienced regional manager, an interim manager and an acting deputy manager were now in post to support the staff and oversee the running of the home. During our inspection visit interviews were taking place for an interim home manager, until a permanent manager could be appointed, and a unit manager for the Dementia Unit. The new regional manager was due to join the service shortly after our inspection.

The provider had contacted us and the local commissioning group when they had identified concerns in March 2017 and had taken robust action to support the service and address the issues identified. They continued to liaise with us and kept us updated of any changes.

We could not see our last inspection ratings displayed and discussed this with the provider's administrator who told us they would address this immediately.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents 18(2) The registered person failed to notify the commission of incidents specified in paragraph (2) which occurred whilst services were being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs 14 (1) (2) (4) (d) People did not always adequately receive support to eat and drink.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1) The provider did not continually assess, monitor and improve the quality and safety of the service. 17(2)(a) The provider had failed to monitor the quality and safety of the service provided,