Donness Nursing Home Limited

Donness Nursing Home

Inspection report

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Ratings

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

Overall summary

An unannounced inspection took place on 2, 9 and 11 December 2015. It was carried out by one inspector, who was accompanied by ex by experience on the first day and a second inspector on the following days. Prior to this inspection, CQC were contacted by a person who raised concerns about the quality of the care and the practice of some staff. Since the inspection, we have been in contact with two people who raised further concerns about staff practice, staffing levels and how concerns were managed.

Donness Nursing Home provides accommodation for up to 34 people who require personal and health care; 29 people were living at the home during our visit. The service provides care for older people; most people are living with dementia. The bedrooms are on all three floors, which can be accessed by a passenger lift.

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

Summary of findings

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions, and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection, no applications had been made to the local authority in relation to most people who lived at the service. This meant people's legal rights were not protected.

Staffing levels were variable and were inconsistent, which did not ensure people were safe or their care and social needs were met.

Recruitment practice did not ensure all the necessary information was in place before some staff started work at the home.

Staff told us they reported concerns about staff practice and the impact of low staffing levels. Senior staff said there were no concerns regarding staff practice; there were no records of the concerns raised by staff.

Staff training was not well managed and systems were not in place to ensure all staff practiced in a safe and caring way. There were many examples of good care, with staff showing affection and compassion towards people. However, there were also practices which undermined people's dignity.

People were supported to see, when needed, health care professionals. Care staff recognised changes to people's physical well-being and knew to share this information with nurses working in the home. Medicines were well managed and administered appropriately. People were supported with their meals, where needed, and people's weight and nutrition monitored.

Safety checks were carried out but some areas of the home were potentially unsafe to people living with dementia.

Activities to motivate people and promote a positive well-being were not routinely available, and there was not a system in place to ensure activities happened regularly and met people's individual interests.

Staff generally had good relationships with people who used the service and spoke about them in a caring and compassionate manner. However, because improvements were needed in staffing levels, skills and knowledge in supporting people with dementia, people were not always provided with meaningful and caring interactions which they needed to reduce the risks of social isolation.

The service was not well led. During our inspection, we found a number of areas that needed to improve to maintain the safety and well-being of people that had not been identified by the providers.

We found multiple breaches of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

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

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12

Summary of findings

months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During the inspection, we shared our concerns about staff practice and staffing levels with the local authority safeguarding team, commissioners and clinical commissioning group who began action to review people's care.

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

The service was not safe.

Staffing levels were inconsistent and poorly planned, which did not ensure people were safe or their care and social needs were met.

People living at the home had not been safeguarded against the risk of abuse.

Risk assessments were not routinely updated after a change in people's care needs.

The recruitment procedure was not effective or robust.

Some aspects of the environment did not protect people and risks to people were not always well managed.

Is the service effective?

Requires improvement

Not all aspects of the service were effective.

Staff training was not well managed and systems were not in place to formally monitor their practice and development needs.

People's legal rights were not protected as deprivation of liberty safeguard applications had not been made.

People were supported to see, when needed, health care professionals. Staff followed their advice.

People were supported to ensure that they had enough food and fluid to support their health needs.

Is the service caring?

Requires improvement

The service was not consistently caring.

There were practices which undermined people's dignity. However, there were many examples of good care, with staff showing affection and compassion towards people.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's social and emotional needs were not always taken into consideration. Activities to motivate people and promote a positive well-being were not routine and there was not a system in place to ensure they happened regularly.

There was no record of complaints to show if they had been effectively investigated, managed and responded to.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

Statutory notifications, required by law, were not always sent to the CQC. This meant CQC was not able to effectively monitor the operation of the service.

The providers had not ensured that there were systems and leadership in place to effectively monitor the culture, quality and safety of the services provided.

Donness Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 unannounced inspection took place on 2, 9 and 11 December 2015. This inspection was brought forward due to concerns about staff practice and the care provided at the home. Three inspectors and an expert by experience undertook the inspection. An expert-by-experience is a person who has personal experience of caring for someone who is living with dementia.

Prior to the inspection, we reviewed all the information we held about the service. This included notifications we had received. A notification is information about important events, which the provider is required to tell us about by law.

We met all of the people who lived at the service and observed staff interactions with them in communal areas of the home. We spoke with six visitors. We looked in detail at six people's care records.

We spoke with 12 staff, which included the office manager, nursing and care staff. We also met with the providers, one of whom was the registered manager. We looked at the staff files for five staff which contained training information and four recruitment files. We looked at the provider's quality monitoring systems which included audits of medicines and safety checks for equipment.

Inadequate

Is the service safe?

Our findings

Staffing levels did not always meet the needs of the people who lived at the home. The registered manager told us they did not use any recognised tools to help them assess the staffing levels needed for each shift. Instead, they based the staffing levels on their knowledge of the people living at the home.

The rotas for four weeks showed staffing levels were not organised to provide consistent cover.

A nurse worked on every shift; the providers are both nurses and work shifts. A nurse was usually supported between four and five care staff in the morning during the week, which included an overlap with care staff working the afternoon shift. A member of the hospitality staff team also worked on each day shift to assist with meals and drinks. This meant there was a good level of support for people at breakfast and lunchtime. However, there were two weekday mornings when there were only three care staff on duty, which was planned rather than due to staff sickness.

After lunch, there was one nurse and care staff numbers reduced to three until 8.30pm. Care staff and the nurse were supported by a hospitality member of staff until 6pm. However, there were ten weekday shifts out of 20 shifts where a care staff member left early at 6pm, which was planned. This left only one nurse and two care staff to provide care. In the late afternoon, many people were requesting to return to their rooms or go to bed. During this time, the nurse administered medicines, while care staff tried to support people's wishes. This meant care staff were based over three floors of the nursing home and regularly had to work in pairs for people who needed additional support. For example, the registered manager said 13 people needed two staff members to move them; this was confirmed by staff.

A staff member said "You should be coming in the evening or at the weekend, then you would see how few of us there are." We stayed in the evening and could see it was hard for staff to monitor everyone's well-being. For example, staffing levels impacted on the quality of care and support for people who had chosen not to go to bed after teatime. There were times when staff were not in communal areas of the home as they were providing care in people's bedrooms. One person, who was assessed as at high risks of falls, was restless, moving objects from different lounges. They went uninvited into another person's bedroom. Another person living at the home said this happened regularly. A staff member who had finished their shift tried to distract them but then had to leave.

This person's care plan said 'close observations must be maintained to support and help to keep (the person) safe' as they were at 'high risk of falls.' However, close observation had not been maintained as they had fallen in the garden in the evening; they were alone. The person had left the building without the staff on duty being aware. The report in the daily notes indicated there were reduced staffing levels when the fall happened.

The registered manager said normally nursing staff would sit in the office in the early evening to complete their records and try to encourage this person to stay with them. However, this arrangement was unsatisfactory as it meant the nurse had to balance completing care records with overseeing a person who was restless and at risk of falls. They also had to respond to the needs of other people who remained in the lounge. We were told this was a time when the atmosphere could become stressed.

At 8.30pm one nurse and two care staff were planned to provide waking cover at night. However, there were 12 shifts out of 28 shifts, which were planned with only one nurse and one care staff member on shift. Staff expressed concern that this had meant people had not been supported as regularly at night as they should have been. This had resulted in some people being left in soiled pads, which were then changed by day staff when they started their shift. They said it was particularly hard at weekends to provide this care in a timely manner. Staff said they struggled to meet people's emotional and physical care needs when they were rushed.

Staff said weekends were particularly busy as staffing levels were less than during the week, which rotas confirmed. A member of staff told us staff cover at the weekend was "always low...usually only three care staff on duty." Rotas showed staffing levels at the home were routinely reduced at the weekend during the day and evening. In the mornings, there were three care staff compared with weekdays mornings when there was usually between four and five care staff. In the afternoons, four shifts out of eight

Is the service safe?

shifts had only two care staff compared with three during the week. The registered manager said there were reduced staffing levels because baths were not given at the weekend so less staff were needed.

However, records for five people did not show that baths took place regularly during the week either. One of these people said to us "I'd love a bath", although a senior staff member said a bath had been offered and the person had declined but records did not reflect that baths were being offered. Staff said baths did not happen regularly because many people were too frail to use the equipment in the bathrooms and there were not enough staff on duty to assist people. One staff member said "It upsets me that I can't do my job properly. We are so rushed there's just no time to bathe people." Another staff member said that in their opinion due to low staffing levels had made bathing "become quite dangerous."

There were not effective arrangements to manage staffing levels when staff were sick and unable to work; they were not always replaced which meant staffing levels were low. For example, one weekend in November 2015, staffing levels had been reduced on three shifts due to staff sickness. Staff said they struggled to meet people's physical care needs. Additional staff had not been arranged; the registered manager said they had not been made aware of staff shortages over the weekend until the following Monday morning. This was despite one of the providers working on the Saturday night shift. There were no contingency plans, such as using bank staff or agency staff. A senior staff said agencies were unable to provide care workers at short notice; they had not kept records to show how they had tried to arrange additional staff to cover sickness. The registered manager said agency staff had only been used to cover one nursing shift in the last three months.

Staff told us that staffing levels had been very low. They said there had been an improvement in the last two weeks and one said "Today, its ok! There are five of us on duty which means we can get everything done."

The layout of the building also impacted on the availability of staff as people's bedrooms are based over three floors. Staff were seen regularly asking where other staff members were in the building as they had no system to check each other's location, apart from using call bells in people's rooms.

This was a breach of Regulation 18 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

Most people were not able to comment directly on their care but several confirmed staffing levels met their needs. People said "They usually come quickly when I use my call bell, it just depends who is on" and "I don't go out of my room much but the staff call in at regular times to make sure I'm alright." A visitor said "I visit every day and there is always enough staff about even at weekends."

A person contacted CQC with concerns about the actions of some staff at the home; they had not felt listened to when they had raised the concerns. We looked at these concerns during our inspection. Care staff said they understood their responsibility to raise concerns about abuse and poor practice. Some staff had not completed safeguarding training; a spot check on training showed three out of five staff had received training in safeguarding vulnerable people. Care staff understood other agencies could be contacted if action was not taken by the registered manager to address their concerns but only one person had done so.

Some care staff members reported they had raised concerns about abusive practice; they were not confident action had been taken to address their concerns. There had been no safeguarding alerts by the registered manager or senior staff relating to these concerns. One person said they felt they were labelled as a 'complainer' and so no longer raised concerns. There was a lack of clarity from the registered manager and senior staff about what had been reported to them and when, as there were no records kept of concerns or the action taken. A senior staff member said they felt confident to challenge staff practice if it needed improving. For example, a staff member's communication style. We looked at records for this staff member but there was no documentation about how this concern had been addressed with them or how their practice had been monitored.

This was a breach of Regulation 13 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

People said they felt safe living at Donness Nursing Home, although one person said they felt uncomfortable with one staff member who shouted at them, because they did not understand them. We shared this information with the registered manager as a concern. A visitor said a person living at the home had shared concerns with them about

the attitude of one staff member. Another person said "Some are kind and some are not." However, another person said "I feel safe because I like the staff and the people living here." Another visitor for another person living at the home said their relative "couldn't be in a better home" and staff were "amazing."

Staff were aware of the risks to people's safety based on their physical needs. For example, where people were at risk of falls and had mobility equipment, staff reminded them to use it when moving around the home. Staff knew a person was unsafe to be left in a wheelchair because of the risk of it tipping so spent time encouraging the person to move into an armchair for their comfort and safety.

Risks to people's safety were increased because the approach to risk was inconsistent. Some risks had not been assessed and others were overdue for review. For example, staff told us and records confirmed that a person became very distressed when staff tried to support them with personal care. There was no guidance for staff as to how to manage the person's distress and reduce the likelihood of them being hit or scratched.

We asked why health professionals had not been consulted to help support the person. The registered manager said they usually allowed a settling in period of up to six to eight weeks and completed a behavioural chart to share with the community psychiatric nurse. The person had lived at the home for 16 weeks and the chart's last entry was in August 2015, although daily records showed the person continued to be distressed and trying to bite and hit staff. One staff member raised a concern that personal care was sometimes poorly managed for this person by some staff because the person could be aggressive towards staff. They said they had shared this concern with senior staff but to their knowledge no action had been taken to reduce this risk.

There were concerns about swallowing difficulties for a person living at the home. The person was referred for a speech and language therapy (SALT) and staff were giving the person a soft mashable diet. The person was given cake to eat with a cup of tea; they started coughing, which staff responded to by adding thickener to their tea as advised. The person said that cake sometimes made them cough, which we fed back to the registered manager as a concern.

Another person had fallen in the garden; they were alone despite their care plan stating they should be closely observed because of their risk of falls. The person's risk assessment had not been reviewed since this incident. In three months after this fall, the person had fallen a further 13 times according to accident records. We asked what action had been taken; the registered manager said the back door was now locked, which staff had been told verbally. There was no record of this decision but the door was locked when we checked. And the GP had visited to review the person's medication needs.

The building had not been adequately risk assessed. A person had gone through the laundry to reach the back door, which had not been locked. The laundry door was also not locked despite there being detergents in the room. These could pose a safety risk if handled by a person unable to understand associated risks from the chemicals.

We had difficulty opening one of the internal fire doors, at our request the providers set off the fire alarm, as the registered manager had reassured us the door would be easier to open under these circumstances as the keypad would be disabled. However, it was not. The registered manager confirmed action had been taken to ensure the fire door released without having to use force. Senior staff said a fire drill had not been carried out for over 12 months, which other staff confirmed. Since the inspection, the registered manager said fire training had now taken place. CQC have contacted the local fire service, who plan to visit the service.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control measures were needed to be improved to keep people safe from cross infection. A person contacted CQC with concerns about poor infection control practice at the home. The registered manager and senior staff told us staff were regularly reminded to follow infection control practices in the home, including wearing gloves and using a small bin to transfer used incontinence pads to the sluice room for disposal. However, we saw a staff member had not followed this instruction. Equipment to dispose of incontinence pads had become blocked on the third day of the inspection; the registered manager said used pads should have been bagged until it had been fixed. Instead, the used pads were left in a small overflowing bin in the sluice room. The registered manager confirmed the

Is the service safe?

equipment would be unblocked. This room had no lock and was accessible to people living at the home. Since the inspection, the registered manager said a lock had been fitted to the sluice room door.

The policy for infection control provided minimal guidance to staff and did not refer to current legislation. It mentioned the risk of infection being spread by visitors but steps had not been taken to reduce this risk, for example, providing hand gel for visitors to use. The registered manager confirmed there were a range of ten slings used by different people but nine of them were not labelled for specific people, which meant there was a risk of cross infection.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was clean; there were no on-going malodours. Visitors confirmed this was always the case. One person said "I like a clean and tidy room and (staff member) always does a good job." Cleaning staff expressed a pride in completing their job to high standard.

Recruitment was not managed in a consistent way, which meant the registered manager could not show how they ensured people were suitable to work at the home. For example, improvements were needed to record the dates of people's past employment history to ensure gaps could be accounted for. There was no identification or a photo for one staff member; the same staff member did not have a current police and disclosure and barring check (DBS) and there was no risk assessment in place to explain the provider's decision. A fourth staff member also had no DBS in place. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. However, former employers provided information regarding people's suitability.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines safely and on time. We checked three people's medicines and found that all doses were given as prescribed. Staff completed a medication administration record (MAR) to document all medicines taken so all doses were accounted for. Correct codes were used and there were no gaps. Each shift, the nurses recorded any concerns they identified and signed to say they had completed the medicine round. Protocols were in place to guide staff when to use 'as required' medicines for managing people's moods and anxieties. However, this had not been introduced for the use of pain killers and laxatives, which meant they could potentially be given inconsistently.

The registered manager had chosen not to introduce photographs of the people living at the home as suggested by a Boots pharmacist in an audit in 2014, as agency nursing staff were not employed by the service and staff knew people well. However, we discussed the introduction of this approach given recent changes in the nursing staff team. Staff checked medicines together against the records when they administered medicines needing a witness and a double signature, which was safe practice.

Requires improvement

Is the service effective?

Our findings

Staff did not receive on-going supervision or periodic appraisals, which meant the registered manager, could not demonstrate how and if the competence of staff had been assessed or maintained. Staff comments and the lack of records in their staff files confirmed this to be the case. For example, one staff member had no supervision documented since 2013. Time had not routinely been set aside to allow staff space to discuss their training developing needs, as well as time to express concerns or share practices that were working well. The registered manager and senior staff said some supervision had taken place in daily conversations between staff and the registered manager. They said there was informal observation of staff practice as the registered manager worked alongside staff on shift. However, they acknowledged this was an area for improvement.

The local nurse educator had provided free training funded by the NHS to staff on a range of care topics. They had fed back to the registered manager to express concern about the negative attitude of some staff to some of these sessions. They said the attendance levels had been variable. The registered manager's view was staff were positive about the training on offer from the nurse educator, which some staff confirmed.

Staff files showed some staff attended more training than others but this had not been addressed by the registered manager. Senior staff confirmed if training had taken place it would be recorded in staff files. Refresher training was not consistently organised in a timely manner. For example, one staff member's medicine training was out of date by nine months. The registered manager confirmed there had been no observation or assessment of any of the nurses' practice in the last year. This included a new member of nursing staff. This meant she could not ensure nursing staff maintained safe medicines administration practice.

Two staff members' moving and handling training was due for renewal in 2014 but this had not been addressed. Some staff practice showed staff were not using equipment safely. Further training was arranged following the inspection. The last training for moving and handling took place in March 2015, a poster advertising the training stated staff would 'not be allowed to continue to work on the floor' if they did not complete it. However, this had not been implemented and staff were still working shifts without updating their training. Some staff practice impacted on people's safety, for example using the wrong size equipment to assist a person and encouraging a person to stand in a manner, which was not documented in their care plan for staff to follow.

There was no overview of staff training so the registered manager could not show how they ensured staff training was up to date. They could not demonstrate how they had ensured staff had the skills to meet the complex needs of people living at the home. For example, some staff had not completed training to meet the needs of people living with dementia. This meant some staff gave instructions too quickly and did not allow people time to process information.

This was a breach of Regulation 18 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

People's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005 in relation to consent. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When

people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. There had been no DoLS applications made for anyone living at the home, despite the information in people's care files indicating this would have been appropriate. For example, one person who was assessed as not having mental capacity about where they lived had left the building unsupervised and had fallen.

Several people moved between two of the lounges but sometimes staff would ask people where they were going and encourage them to sit back down. One staff member stood in front of a person's walking frame to stop them moving forward. They said they were concerned the person would fall; the person kept getting up. Their care plan stated they became restless when they needed to use the toilet but staff did not offer this option to them. Instead, staff were busy outside of the lounge.

Requires improvement

Is the service effective?

By the end of the inspection, senior staff had begun to complete applications for six people. We discussed with senior staff that this figure may need to be reviewed again to reflect the needs of people living at the home and the level of staff supervision they received.

Where people lacked capacity, there was not consistent documentary evidence to show that people's capacity to make particular decisions at a particular time had been assessed or records of best interest decisions made. For example, one person living with dementia had bedrails and a motion device, which staff used to monitor their safety and wellbeing. This meant the person was under constant supervision, a restriction on their liberty. However, there was no record of a best interest decision about this. Another person said they had not chosen to share a room, the registered manager said this had been discussed with them and they had benefited emotionally from sharing but records did not reflect how this decision had been reached.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A senior staff member confirmed they had undertaken MCA training and completed a consent to care checklist where they made a judgment about people's capacity to consent. For example, records showed some people had requested bed rails to make them feel more secure and we saw these were in place. People's daily records did not routinely indicate people had consented to care. But in their conversations with people, most staff checked how they wanted to be supported, although one person told us there was a lack of choice with regards who they sat with at mealtimes. People told us they chose when to get up; some people said they chose to stay in bed.

People's care plans included information about what support the person needed to participate in decisions about their care, in accordance with the MCA. For example, one person's mobility support plan included information about how staff could support the person to participate in decisions about moving. This included instructions for staff to involve the person by 'giving full and continued explanations' and 'use communication that she can understand. Add actions with words to enhance this'. We saw staff following this advice.

People's physical health care needs were met by staff who knew about their care and treatment needs. Staff handovers took place before each shift and the information was detailed to ensure nursing and care staff were kept updated about people's care needs. Records were also kept of agreed action, such as requesting a GP to visit. Care staff said they were kept updated and knew their responsibility to report changes to nursing staff, which a nurse confirmed.

Staff worked with local healthcare professionals such as GPs and dieticians, which was demonstrated through advice recorded in people's daily notes and actions by nursing staff to advise GPs of changes. However, it was not always easy to track back how and when changes to people's care had been decided and by whom because professional advice was not routinely recorded separately from the daily records. This meant it was difficult to establish a clear timeline of decisions and resulting changes to care.

Three GPs confirmed staff sought advice appropriately about people's health needs in a timely manner and followed advice from GPs. They described nursing staff as being knowledgeable about the people they cared for. Staff were described as helpful and having a good rapport with people living at the home. One of the nurses described how she had reminded a GP about the multiple health issues experienced by one of the people so he was aware of the risks to the person's health. The nurse described to staff how she had reminded the GP to be patient with the person to give them time to answer and be included. The nurse provided a positive role model and a visitor praised the nurse's approach.

People said "The food is OK, it just depends which cook is on" and "I have my meals in my room by choice, it's usually hot." Another person said the food was "OK." A visitor said "My relative has to be given food and drink as they can't do it themselves but they are very good with(the person)." Several people in the dining room commented favourably on a lunchtime meal saying "The pork was lovely." At lunchtime, there was one main meal, although catering staff said they knew each person's food likes and dislikes and gave examples when they would produce an alternative. For example, they would prepare an omelette or jacket potato instead. During three lunchtime meals, a choice of dessert was not offered to everyone; one individual was provided with yoghurt, which staff said the person liked. People were not routinely offered a choice of cold drink.

Requires improvement

Is the service effective?

The menu for the day was displayed in the hallway but not in the dining room where it would have been more accessible for the people using this room. Some staff did not take the time to tell people what the food was on their plate; this included people being supported with a meal in the dining room. This meant some people living with dementia had food put in their mouths without knowing what it was. However, other staff practice was kind and caring, which included pacing their support so people were not rushed to eat. Throughout the inspection, people were encouraged to drink and provided with drinks.

Staff explained they would meet with people when they moved to the home to understand their dietary needs and preferences. There was a four week menu, which staff said was not seasonal, apart from additional salads in the summer. We asked how people influenced this menu but there was no formal way this was reviewed with people.

Where there were any concerns about nutrition and hydration, there was a care plan in place. Staff said there was no one currently on a food and fluid chart to monitor diet. Catering staff were aware of people who had lost weight, although a sample of records showed people's weights were stabilising. They explained how additional drink supplements were used to boost these people's diet, and cream and full fat milk was added to food to add calories to people's intake. Records showed GPs were notified of people's weight loss. People's weights were recorded on a monthly basis. However, this action was not increased, for example to weekly weights, when people had unplanned weight loss, which demonstrated that some risks were not managed proactively.

The design of the building did not always support people's independence. One person went into other people's room, which staff and another person living at the home confirmed. We also saw this happening. Bedroom doors were only numbered with no names or features to help people distinguish one room from another. Some people had difficulty remembering the number of their bedroom. One bedroom corridor was gloomy and on many occasions the lights had been turned off. Some people living with dementia can have a visual impairment and this poorly lit area could inhibit their independence and impact on their perception of the area. For example, one person, who according to accident records had fallen on a number of occasions, was told by a staff member not to try and pick up the flowers as they were part of the carpet. We saw them trying to pick up the carpet pattern on another occasion and a fall reported in the accident book also referenced the person trying to 'pick up the flowers' . We discussed the design of some of the carpeting in the communal areas with the registered manager as it was highly patterned

We recommend the providers consult current guidance on the design of environments for people living with dementia.

Requires improvement

Is the service caring?

Our findings

The lack of regular staff supervisions, observations of staff practice and team meetings impacted on the quality of care provided. As a result some staff practices undermined people's dignity. For example, staff used the terms the "feeders" for people who needed support with their meals and "walkers" for people who were mobile. Staff called protective clothing a 'bib', which is a term generally used for children's protective clothing. One staff member was seen encouraging people to say thank you when offering them a drink or a cake. Their approach did not treat people as equals and instead treated adults like children. A number of staff told people they were 'a good girl' when they were compliant with care, which patronised people.

Hot drinks were served in brightly coloured plastic mugs; the registered manager said this was because some people struggled with heavier mugs. There was not an individualised approach and consideration had not been given to the different needs and wishes of people. For example, visitors were asked if they would prefer a ceramic mug but people living at the home were not offered this option. A person who was seen to eat independently on other occasions was hand fed a cake by a staff member; the staff member spoke with other people at the same time. This undermined the person's dignity.

Mealtimes had an institutional style. For example, when the rooms used for breakfast or lunchtime were not in use, tablecloths were in place. However, when people sat at the tables for meals, these were removed. Meals were served directly onto tables; there were no place settings or condiments. People were not always offered the opportunity of a choice of drinks. Napkins were not provided; instead staff tore off strips from a kitchen roll. In the dining room, a person was supported to eat a meal by a staff member who was standing beside them, which was not best practice. A staff member corrected a person by calling across the room when they did not use the usual cutlery to eat their meal. This type of mealtime experience did not encourage people to linger or relax over their meal. However, staff did play music and sang along to try and create a social event, on one occasion they danced with a person as they waited for their meal.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In contrast to the above examples, we also saw many kind and caring interactions between staff and people living at the home. In one person's care plan it stated they needed reassurance and affection, and we saw staff recognising their anxiety and cuddling them. The person looked relaxed and happy during these times. A person told another staff member "You're lovely." We asked people if staff were caring, some people did not answer directly. For example, one person said the staff were "all right...I'm not unhappy" and they commented positively on a new staff member. However, another person said some staff were "gentle" and a relative said "they look after (the person) very well", which we could see when we met with the person.

On two occasions, people were supported by staff in the lounge to eat a meal. Staff members took time to explain what the meal was, checking the temperature with people and assisting them at a slow pace which met the person's needs. The atmosphere was calm and unrushed. When a person showed a dislike for the food offered, staff took time to try different food to encourage them to eat. Staff shared their knowledge of the person's likes and dislikes with each other to try and establish a food which the person would prefer as the person was not able to verbally communicate their wishes. Staff took the time to interpret people's facial expressions when they were unable to verbally communicate their views.

There were other examples of good practice. One person was very restless and a staff member spoke to them kindly and treated them as an equal in the way they spoke with them, although we saw they were also busy trying to complete other tasks. The person responded well to them and for a while sat with the staff member while they completed paperwork. Another staff member encouraged the person to have a drink and something to eat to encourage them to settle, despite the staff member having reached the end of their shift.

Staff supported people discreetly, for example, recognising when people's clothes needed to be changed and gently encouraging them to return to their bedroom for assistance. People told us staff ensured doors and curtains were closed before supporting them with personal care. One person told us they were feeling unwell and with their agreement we told staff. Staff responded quickly and

Requires improvement

Is the service caring?

appropriately, checking with the person how they wanted to be supported. Another person was having trouble with using the phone and staff offered to support to help them make the call.

Written compliments were kept by the providers. They included comments such as "You have all been so lovely and kind and very welcoming", "(The person) was always treated with the utmost courtesy and respect" and "Thanks for all the kindness shown me in the last few days." People looked well cared for. For example, people looked well presented, with clean clothes and there was evidence that people's flannels and toothbrush had been used, which reflected people's daily records for assistance with personal hygiene. Visitors told us their relative's clothes were always clean and their appearance was maintained by staff.

The registered manager and staff told us there was nobody living at the home with end of life care needs. The registered manager and a nurse working at the home had completed end of life care training; care records for a person had died at the home prior to our inspection showed nursing staff had consulted health professionals and monitored the person's well-being and pain relief. Information from two health professional who worked with people at the end of life earlier in 2015 indicated there were no concerns about how end of life was delivered.

Requires improvement

Is the service responsive?

Our findings

The complaints process lacked helpful information and despite a written commitment to learn from complaints no records were kept. The complaints policy stated people should discuss concerns with their keyworker and then if not satisfied to see the nurse on duty, then if still not satisfied the matron. The procedure given to people living at the home encouraged people to speak with the nurse in charge, the matron or CQC. Neither gave timescales for a response or provided information about outside agencies such as the local authority or the ombudsman. Not all of the staff wore names badges and there was no information about the names of staff on display, which potentially could make it difficult to complain about individuals. Some people commented they would feel safer if they knew the name of the person who was attending to them.

Complaints were not recorded from people living at the home or their representatives or from staff. The registered manager said they had not received any complaints since the last inspection in 2014. However, information from an individual safeguarding alert made in July 2015 showed they had met with a complainant. The registered manager and senior staff said they had met with the individual to resolve their complaint; there was no record of this meeting in the home. One of the complainant's concerns had been that a call bell was not always accessible for their relative to use.

As there was no record of the complaint, the registered manager could not demonstrate if there had been any resulting action based on the concerns raised, such as the availability of call bells. During our inspection most people had an accessible call bell near them in their room, apart from one person. However, people in communal areas had to rely on calling out if they needed staff assistance. One person said "I ought to have a bell." We advised the registered manager this had resulted in a verbal altercation between two people in one of the lounges when staff were busy elsewhere. Records of complaints and concerns were not in place to enable the registered manager to recognise themes and patterns.

The home's statement of purpose said 'constructive criticism is a helpful tool to enable us to ensure that we are providing a good service at all times'. The complaints policy stated 'staff should take up complaints/grievances with matron. These will be recorded and appropriate action taken'. However, some staff felt they would not be listened to if they whistle blew about abuse or poor practice. Staff members said they had reported practice issues to senior staff, but were not confident these had been followed up and addressed by the registered manager. Staff said they did not go to the registered manager but usually reported concerns to senior staff. The registered manager and senior staff said they had not had concerns reported to them, which contradicted what staff told us. There were no records of concerns or complaints raised by staff.

There was no record kept of concerns. Discussion took place about how concerns rather than formal complaints could be captured centrally by the registered manager. Currently there was not a system to identify if there were themes and patterns emerging from which improvements could be made.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We focussed on the care needs for six people. People's care needs had been assessed based on a range of information and each person had a care plan. People's care plans provided personal information but this was not always followed by staff. For example, one person needed to be encouraged to drink. It was noted they did not like 'plastic/ melamine mugs' and the risk would be they would decline fluids. We saw the person having a drink served in a bright plastic mug, they looked at the mug and said "what is this?"; the staff member said "it's tea" and encouraged them to drink. Senior staff said people were assessed before moving in but records did not routinely show how people had been involved in their care plan, although people had been assessed for their ability to consent to care.

Two visitors told us that they were consulted about their relative's care who was living with dementia and were confident they would be kept informed regarding changes to their health. They had looked around before their relative had moved to the home and confirmed a member of staff had assessed their relative's care needs before the person moved to the home. This reflected a detailed assessment in the person's file.

Care plans described people's care needs, for example highlighting when people's skin was fragile. Pressure relieving equipment was in place, although care plans did not routinely list all the equipment which was in use to

Requires improvement

Is the service responsive?

prevent the risk of pressure damage. For example, pressure relieving cushions were in place for people in their rooms but these were not referred to in their care plans. Staff confirmed there was no one living at the home with a pressure sore, which showed risks were recognised and managed. Care plans, apart from one person's, did not state what type of sling was required, which could potentially lead to inconsistent and unsafe practice.

Staff practice showed they usually observed changes in people's well-being and reported on them appropriately. For example, one person's feet had become swollen and care staff reported this to the nurse on duty and encouraged the person to sit down and elevate their legs. Records showed nursing staff had reported changes in people's physical health to GPs.

During our visit some people told us they were bored; some visitors expressed concern there was not enough stimulation for their relatives. There was a reliance on the television to provide stimulation. For example, the television was left on for long periods of time in both lounges; one person was alone in one lounge and said they did not want the television on. Another person who chose to stay in their room said staff just put on the television and it was not their choice. A staff member confirmed the person preferred "peace and quiet." One person was feeling unwell and was sitting alone in one of the lounges waiting for their meal. At one point televisions in both lounges, which were adjacent, were left on at a loud volume. The person struggled to hear what staff said when they tried to assist them.

People's care records did not demonstrate how staff supported people to engage in activities of interest to them. Care staff said they tried to fit in activities when there was time but acknowledged they did not usually record this happening. On the third day of our inspection, a game of skittles took place in the lounge which some people participated in and from their expressions enjoyed. A few people were encouraged to participate in colouring in pictures and one person looked at a book on nature. People in their bedrooms said they passed the time watching the television, looking at magazines or listening to music.

One person's care plan said 'All efforts should be made to make (the person) feel wanted, empowered, lift her mood, stimulate her with company as she desires.' There was recognition that the person had fears of rejection and needed to build a trusting relationship with staff. Records relating this person's care did not show if this had been achieved. Staff spoke with the person when they were assisting them to move, sometimes in a bantering way and other times more gently but staff did not generally have time to talk with people unless they were assisting them with a task.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We were provided with service's 'philosophy of care'. This was out of date as it referenced a previous regulatory body's guidelines. Some of the aims had not been met, such as all staff will be appropriately qualified and there will a programme of activities. A six monthly audit completed by senior staff and the registered manager in July 2015 regarding the 'quality, safety and effectiveness performance' had not identified areas for improvement.

The quality and safety of the service was not assessed or monitored effectively. The providers both work on shift at the home as nurses. The rota did not show one of the providers, who is also the registered manager, as working on any shifts related to running the home. She had created a role of office manager for a senior staff member, who was undertaking management training. She had delegated some tasks to the office manager and other nurses within the home. This included applying for deprivation of liberty safeguards applications but none had been made despite some people living at the home meeting the criteria.

The home's statement of purpose said 'all employees undergo a rigorous employment process to ensure their suitability'. The registered manager and senior staff managed recruitment in the home but there were not rigorous employment processes to help keep people safe. Exit interviews did not take place and therefore the registered manager could not demonstrate if there was a theme or patterns to why staff left. Staff said there had been several staff who had left recently.

Staffing levels were poorly managed and were not organised to provide consistent cover. Staff said this impacted on the type of care they could provide. A senior staff member said the responsibility of planning the rota was shared with the registered manager. The communication between staff and the registered manager was not always effective. For example, one weekend in December 2015 , three shifts were below the numbers on the rota due to staff sickness but the registered manager said they had not been made aware of the issue until the following Monday. They live close to the nursing home and said staff could have contacted them.

The registered manager and senior staff told us it was the staff members' responsibility to attend training if it had been arranged for them. There were no systems in place to check whether staff needed updates and as a result some staff training was out of date. Therefore the registered manager did not ensure the training and skills of staff kept people safe. Appropriate action was not taken when staff did not attend, despite information stating they would be prevented from working without the correct training.

There was not always an accurate, complete record in respect of each person. The home's statement of purpose said care plans would be reviewed monthly or more frequently, if required. The registered manager had delegated the review of care plans and risk assessments to other staff but had not audited the quality of the reviews, some of which were overdue. Reviews of risk assessments were not routinely in depth or meaningful. For example, records did not show what action was taken after a person had fallen alone in the garden. Or if a safeguarding referral or further training for staff had been considered. The registered manager had not reviewed how people's social and emotional needs were being met. Activities to motivate people and promote a positive well-being were not routinely recorded and there was not a system in place to ensure they were appropriate to the person or happened regularly.

Staff did not receive a regular appraisal of their performance in their role. Spot checks had not been completed by the registered manager to ensure staff were working in an appropriate manner. Due to the lack of supervision arrangements or appraisals for staff, the registered manager could not formally show how they monitored the quality of care at the home. They said they worked alongside staff in their nursing role which enabled them to informally monitor staff practice. However, they had not addressed practices, which undermined people's dignity.

Regular team meetings did not take place so staff were not given a formal opportunity to raise concerns or share their views on what was working well in the home. The minutes from the last team meeting in March 2015 did not demonstrate this was a place where staff views were valued. The records of the minutes were brief. They stated 'staff aired their views' but there was no record of what was discussed or if action needed to be taken. Staff told us staffing levels had been raised as a concern. Some staff reported low morale and said they no longer enjoyed working at the home, one named poor staffing levels as a

reason. However, two staff members said they felt well supported by the registered manager on an informal basis. One had not received any supervision in the last year but felt "valued".

The minutes for the last team meeting recorded 'Matron has been here 34 years. There has always been conflict between staff – this is a good thing – shows staff care about what they are doing. All of us make mistakes – no one is perfect. Checking on others improves practices. No one does things wrong – just could have done some things better. We are all human.' This statement did not promote a harmonious working environment and suggests poor management of staff. It indicates a lack of understanding regarding abusive behaviour. There was no reference to the impact on people living at the home showing the culture of the home was not person centred. This was reflected in a lack of meetings to enable people living at the home and their representatives to give feedback and influence the service.

Since the inspection, the registered manager has sent information relating to how they have addressed a concern about staff practice. This was discussed in a group setting, which may have inhibited people disclosing information. Former staff have raised this approach as a concern and confirmed they have raised previous concerns about a staff member's practice. Staff told us a senior staff member was approachable but they were not confident all concerns were passed to the registered manager and if the registered manager acted upon the information. There were no records in place to demonstrate how concerns were shared with the registered manager. There were no records of any complaints by people visiting the home since the last inspection, although the registered manager had met with a complainant following a safeguarding alert.

Some aspects of the service were not assessed to ensure they were safe and risks reduced. For example, staff said there had not been a fire drill for over 12 months; we confirmed this with a senior staff member. The home's fire policy said drills 'will be carried out in every period of six months'. It stated night staff would have fire training every three months; one staff member's file had no fire training logged. It stated day staff would have fire training every six months; one staff member's file had no fire training logged in 12 months, apart from a tour of fire exits on their first day.

The registered manager could not demonstrate that all the fire exits were accessible; one fire door which was an emergency exit route was stiff and difficult to open. The sluice room and the laundry were unlocked and in areas of the home accessible to people living with dementia; The registered manager had not considered the safety of people living at the home. The registered manager has confirmed these concerns have been addressed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there was not an effective system to regularly monitor and assess quality of the service and the risks to people living at the home.

Maintenance of the building and equipment took place, which included safety checks and servicing contracts for fire safety equipment, gas, electrics and lifting equipment. The lift to the ground floor had been temporarily out of action but maintenance staff came during the inspection to fix it. There were areas where further safety checks were needed, which included a review of the maintenance of wheelchairs and how the risks of non-integral bed rails were checked. These were highlighted to the registered manager, who responded quickly to confirm the work was now in progress on the wheelchair. They had told us all bed rails were integral so we recommended they checked which type of bed rails were in use and how they monitored their safe positioning.

Surveys were provided in an information pack to gain visitors' views on the quality of the service; we requested copies of the responses and were provided with a sample of three recent visitor responses from 2015 and one from 2014. These contained positive comments about the quality of care and the attitude of staff. We also saw copies of two letters dated early 2015 from visitors praising the 'warm welcome' and the 'years of care'. Visitors told us the staff were "very friendly".

Statutory notifications, required by law, were not always sent to the CQC. This meant CQC was not able to effectively monitor the operation of the service. Notifications had not been made to CQC regarding people who had recently died at the home. The registered manager had not submitted notifications to CQC to cover all notifiable events in the home. During the inspection, we discussed one of the notifiable incidents that linked to people's safety with the registered manager, who said a notification had been

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submitted but had no record to show this. Another person had fallen and fractured their nose requiring an assessment by hospital staff, which the registered manager and senior staff confirmed had not been notified to CQC.

This was a breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009 because CQC had not been notified of incidents within the service.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have suitable arrangements in place in order to ensure that persons employed for the purpose of the regulated activity were appropriately supported in relation to their responsibilities.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not have suitable arrangements in place to ensure people's social and emotional needs were met by person centred activities.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place for obtaining, and acting in accordance with the consent of people who used the service in relation to the care and treatment provided to them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Risks associated with people's care were not effectively assessed and managed to ensure people received safe care.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Systems for protecting people from abuse and improper treatment were not effective and did not provide confidence to staff that their concerns would be acted upon.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services **The registered provider had not fulfilled their statutory obligations to the CQC with regard to notifications of deaths of people using the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered provider had not fulfilled their statutory obligations to the CQC with regard to notifications of other incidents in the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider did not have suitable arrangements in place to ensure people's dignity was maintained in a consistent manner.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Action we have told the provider to take

The provider's systems were not effective in ensuring effective infection control measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider's systems were not effective in providing an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider's recruitment procedures were not effective in ensuring staff were 'fit and proper' to work at the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have suitable systems in place to ensure there were sufficient numbers of qualified, skilled and experienced persons employed to meet people's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider's systems were not effective in monitoring the quality of service provision.**