Rushcliffe Care Limited

Partridge Care Centre

Inspection report

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Ratings

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

Overall summary

The inspection took place on the 14 and 15 January 2016 and was unannounced. Partridge Care Centre is a purpose built home set over three floors. It provides personal and nursing care for up to 117 older people, some of whom live with dementia. At the time of our inspection 73 people were using the service. Following our previous inspection of the service in July 2015 we imposed a condition on the provider's registration to prevent them from admitting any further people to Partridge Care Centre because of the concerns that we found.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, there were management arrangements in place as the deputy manager was performing the role of manager and the clinical lead was acting as their deputy.

Summary of findings

The provider contracted an independent health and social care consultant to help support the interim managers of the service in the absence of a registered manager.

When we last inspected the service on 23 July 2015 we found it was not meeting the required standards. We found breaches of the Regulations in relation to safe care and treatment, staffing, safeguarding people, consent, privacy and dignity, person-centred care, good governance and notifiable incidents to CQC. At this inspection we found the provider continued to be in breach of regulations. Although some improvement had been made the provider had not taken sufficient action to ensure people received safe, effective and compassionate care.

We found that there were inconsistencies in meeting people's needs safely at all times. The provider was using a high number of agency staff to cover for staff vacancies and both planned and unforeseen absences. This was poorly managed and the agency staff used had not been given access to up to date information about how to care for people in a safe way. For example, a safe induction process was not operated for agency staff who had not had their skills and competency assessed to ensure they were able to provide care safely. Care records were available for agency staff to read however these were not detailed enough to ensure they were able to support people safely and appropriately.

People identified as being at risk through falls had experienced harm because the risks had not been managed effectively.

People were assisted by staff who used unsafe moving and handling techniques. For example, helping people to stand up by lifting and pulling under their arms. Recommendations from occupational therapy staff were not always reflected in the people's care plans or put into practice. Staff were not familiar with the recommendations made on how to use equipment to assist people with their transfers.

Some people's freedom of movement was restricted and restrained in ways that did not comply with nationally recognised good practice or the deprivation of liberty safeguards (DoLS). For example, people's freedom of movement was restricted by the use of tables, mobility equipment such as Zimmer frames being removed or placed out of reach, and by physical restraint observed by the inspection team. The processes designed to ensure people were safe with the least restrictions on their freedom were not followed.

Accidents and incidents were monitored and reported to the local safeguarding team and CQC where necessary and appropriate. However, there were lack of internal systems to identify trends and patterns and there was a lack of action taken to prevent accidents and incidents from reoccurring.

People who needed their food to be pureed and their drinks thickened to mitigate the risk of chocking were administered some of their medicines in tablet form. This was not discussed with the GP or the specialist speech and language therapist team (SALT) to ensure that having medicines in tablet form had not increased the risk of choking.

There were significant differences in the skills and knowledge demonstrated by permanently employed staff and agency staff. Permanently employed staff had comprehensive training and were able to tell us their responsibility towards people under the safeguarding procedure, signs of abuse and they were confident that their report will be taken seriously by the management team and acted on. Not all agency staff was familiar with the safeguarding procedure or knew how to recognise and report possible abuse.

Safe and effective recruitment practices were followed to check that staff were of good character, physically and mentally fit for the role and able to meet people's needs. However, there was a high turnover of staff; the provider told us permanent staff vacancies were difficult to fill due to candidates not meeting the standards required.

We found that people had their medicines administered by nurses who were trained and had their competencies monitored by the manager. There were regular effective audits carried out in relation to medicines which identified any errors and these were dealt with promptly.

People had mixed views about the quality of the food provided, however they all said there were alternatives and always two choices offered.

Communication between management, staff and people who lived at the home had improved since our last inspection. There were more effective hand over

Summary of findings

processes and also a daily meeting where staff had the opportunity to report any concerns they may had about people`s needs. Staff, relatives and people told us about the management arrangements and confirmed that management was visible and approachable.

Records were reflective of people`s needs and were regularly reviewed by staff. However, we found that care plans were generic and had little person centred information about people`s likes and dislikes. There was little involvement from people or their representative in care reviews, particularly when peoples` needs changed.

The management team had implemented systems to monitor and improve the quality of the service provided; however some areas like accident and incident analysis were not as effective as they should have been. There were regular relatives and staff meetings.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always safe from avoidable harm due to the high numbers of agency staff used who were not familiar with their needs.

Permanent staff were able to describe how to recognise and report allegations of abuse, however agency staff was not familiar with the safeguarding procedure.

People were at risk of injuries due to the unsafe moving and handling techniques used by staff.

Risks to people`s health and welfare were identified. However the plans to mitigate the risks were not detailed enough for staff to keep people safe.

People's medicines were managed safely by trained staff.

Permanent staff who worked at the service were employed following robust recruitment processes.

Is the service effective?

Inadequate

The service was not effective.

People`s day to day needs had not always been met effectively, due to different skills and knowledge between permanent and agency staff.

Mental capacity assessments and best interest processes were not followed to ensure the techniques used to keep people safe were the least restrictive to people`s freedom.

Deprivation of Liberty Safeguards applications were submitted to the relevant authorities. However these were not specifically relevant to the forms of restraint used.

Permanent staff were supported and had received the training to develop skills to meet people's needs effectively. However, agency staff had not had their skills and competency assessed to ensure they were able to provide care effectively.

Is the service caring?

Requires improvement

The service was not always caring.

Staff showed respect to people, they were kind and caring in their approach, however there was little continuity for people to form bonds due to the high turnover of staff.

Staff showed empathy, patience and a calm approach when caring for people who lived with dementia.

Summary of findings

People`s dignity and privacy was respected and promoted by staff in most circumstances. However at times staff`s behaviour was detrimental to people`s dignity.

Is the service responsive?

Requires improvement 

The service was not always responsive.

People had comprehensive care plans to detail their physical and health needs. However, they lacked detail about people`s preferences, likes and dislikes.

Activities provided varied and people who were in their bedrooms all the time only had individual activities once a week.

People, staff and relatives felt their voices were listened too. However, they had little confidence that their views were used to improve the service.

Complaints were appropriately logged, however there were not always appropriately investigated and responded by the acting manager.

Is the service well-led?

Inadequate 

The service was not well led.

The service had no registered manager since May 2015.

The acting manager had developed systems to monitor and improve the quality and safety of the service provided, however these were not well established or robust enough.

The provider was not able to demonstrate how they monitored that staffing levels matched people's needs or that staff were appropriately deployed.

The provider had not risk assessed the impact on the quality and safety of the care people received due to the high number of agency staff used.

The provider had not ensured the care records for people were detailed enough for staff to provide safe care.

Staff, relatives and people felt the management arrangements in the home were good and managers were approachable.

Partridge Care Centre

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 made the necessary improvements and was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012.

The inspection was carried out on the 14 and 15 January 2016 and was unannounced. The inspection team consisted of three inspectors and an occupational therapist specialist advisor.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

We carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

During the inspection we spoke with five people who lived at the home, six relatives, seven regular care staff, five agency staff, two nurses, two team leaders, maintenance staff, the deputy manager, the acting manager and an independent health and social care consultant who supported the management team. We looked at care records relating to 10 people and four staff files together with other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At our last inspection we found that the service was not safe, the provider failed to ensure they had sufficient numbers of staff to meet people`s needs safely at all times. At this inspection we found that although there had been improvements in the number of staff deployed people did not receive safe and effective care because not all staff were aware of people's needs. Only 50 percent of staff working at the service were permanently employed, the management was covering the available staff hours with agency staff.

People told us they felt safe at the service when permanent staff looked after their needs. One person told us, "I feel physically safe here." Another person said, "I feel safe when the care staff I know are working, agency staff are not very good." One relative told us, "People are very safe here; the staff call us when it is a change, like a fall or a urinary tract infection, even for a behaviour change."

However, we found that the quality and safety of the care people received was inconsistent. Permanently employed staff had a good understanding of people`s needs, however when agency staff were used to cover for staff shortages people were at risk of harm. For example, we found that one person who fell out of bed and injured their face lay unattended for longer than was necessary or safe. This was because the agency staff who settled them into bed had not plugged in the alarmed pressure floor mat. Permanent staff told us that there was a need for the alarm mat to be plugged in when this person was in bed; however the quick reference guide for care for this person had no detail about this. Agency staff were prompted at handovers to check the quick reference guides; however we found that these were not always up to date with how to mitigate the risk for people. This meant that agency staff were not given the information they needed to provide care which was safe and met people`s needs.

Permanent staff told us that although staffing numbers had improved and been maintained, the high use of agency staff had meant that it remained difficult to provide safe and effective care. They told us that agency staff were not knowledgeable about people`s needs or how to deliver care safely which put additional pressures on permanent staff. One permanent staff member told us, "We really try hard to keep people happy and safe but it is very hard when we work with so many agency." Another permanent staff member said, "The only issue here is the agency staff, some of whom are not very good and quite happy just to sit and let us permanent staff do all the work."

We asked the management team to tell us how they established the staffing levels required at the home in order to meet people's needs safely. The acting manager told us, "Staffing levels have remained the same although the numbers of residents dropped, sickness can still be problems however we work with three agencies and generally have a consistent group of agency workers." However, two of the agency workers at the home on the day of the inspections told us they only worked a maximum of two occasions on the same unit.

The dependency tool used to determine staffing levels has not changed since our last inspection. We found that it was ineffective in establishing staff ratios because it did not provide a reflective view of people's dependency needs. For example, the time needed for two staff members to reposition people at risk of pressure ulcers was not considered. This meant that there was a possibility that the staffing ratios were not meeting people`s needs.

The manager told us they reviewed staffing at meetings every day and when they visited each unit which meant staff could be re-deployed where there was a need for it. However they did not consider the ratio between permanent and agency staff. On occasions more agency staff worked on some units than permanent staff. One relative told us, "The care received now is not as proactive and I believe this is due to the changes in staff. There are always far too many agency staff working which means that client familiarity is not there." This meant that the care people received was not always consistent, safe or met their needs because there were not always sufficient numbers of suitable staff available to meet their individual needs.

We found that the provider had recruited 19 staff since September 2015; however there was slow progress in building a permanent staff team. Partially because 16 staff had left during this time. Also the consultant explained the difficulties they experienced in finding candidates who met the provider's required standards. The provider had not conducted any formal exit interviews to establish the reason why staff were leaving, however they told us some staff had left as a result of the provider taking action to manage their performance.

Inadequate

Is the service safe?

We found that this was a continuous breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider has not ensured that they had sufficient numbers of qualified competent and skilled staff to meet peoples` needs safely.

People sustained injuries because identified risks were not always assessed or mitigated safely. We found that some people had sustained unexplained bruising and injuries which were not always investigated to reduce the risks and prevent reoccurrence. For example, one person had three accidents, two of which happened when staff transported them in their wheelchair and resulted in an injured foot and cut hands. However, this did not trigger an investigation into what happened or a review of how the person was supported to move around the home safely. The only action taken was to remind staff that the person lived with dementia and to ensure they didn't hurt themselves when being mobilised.

We found that another person had a fall from their sling when they were hoisted by staff. Again, this was recorded in the person`s manual handling notes, however there was no accident form to detail if the person had sustained any injuries. The accident had not triggered a review of the person's mobility or moving and handling needs. The person's falls risk assessment wrongly detailed that the person had not fallen in 12 months. However we found that they had fallen three times over a short period of time. Important information relating to accidents was not reported to management for further investigation and a re-assessment of people`s needs. This meant that people had not received safe care and treatment in a way that both recognised and mitigated identified risks.

We found that this was a continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider has not ensured that assessments of the risks to people's health and welfare were carried out, mitigated and reviewed when it was required.

At our last inspection we found that staff had not received appropriate training to ensure they were provided with the knowledge and skills to carry out their roles safely. At this inspection we saw that a range of training, including moving and handling, first aid, safeguarding, dignity training and dementia training has been provided for staff. However, our observations found that some staff did not always follow safe procedures and practices when supporting people to move around.

We observed staff assisting a person to walk using a handling belt; the belt was fitted incorrectly and out of position. We spoke to a nurse who told us the belt was in good working order but staff were using it incorrectly. On the second day of the inspection the same nurse told us they had demonstrated to staff on the unit how to use the belt correctly after we raised concerns about the manoeuvre the previous day. We observed staff not following the best practice they learned in training. For example they were using wheelchairs to transport people from one area of the home to the other without having a lap belt fastened.

People were left sitting in wheelchairs without having the foot plates folded back. We observed people placing their feet on the floor behind the foot plates which increased the risk of them being injured by the metal plates when staff moved the wheelchair. We also observed a person hoisted by two members of staff using a stand aid. When the staff raised the hoist the sling had moved up and caused the person to shout out in pain telling staff that they had hurt their arm. They lifted their arm out of the sling which could have led for them to have a fall; however they landed back on the wheelchair behind them. Staff lowered the hoist, adjusted the sling to be more tight and in better position, they then asked the person to hold on to the hoist which they omitted to do previously and started the procedure again. We asked staff if this was the correct procedure and if this required reporting. Staff told us that the person was often difficult to hoist, and said that they should report this; however records did not show that this had been reported or reviewed. This meant that the risks associated with this manual handling procedure were not reported to managers and were not reviewed to ensure they were safe for the person.

An occupational therapist had visited from the local authority to carry out assessments following concerns identified during our inspection in July 2015. Although they had provided guidance this had not been consistently used to review manual handling assessments. For example, on one assessment they advised staff to use a specific loop on the hoist sling; this had not been recorded on the manual handling assessment. We asked four staff if they knew what

Is the service safe?

loop to use and only two staff were aware of this advice. We asked an agency staff if they knew which sling and loop to use when they hoisted people, they told us, "Depends of which staff I am working with, sometimes we use the green sometimes the orange loop for the same people."

We found that this was a continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider has not ensured that the staff providing care to people had the competence and skills to do it safely.

The majority of permanent staff were able to tell us their responsibilities about how to safeguard people from abuse and avoidable harm. They knew the signs and indicators that could suggest abuse and how to raise any concerns. Permanent staff were confident that their concerns were taken seriously by the management team and they confirmed that any reports of bruises and injuries were looked at by the manager or deputy manager. However we found that when incidents occurred there were no `lessons learned` actions to ensure staff were aware how to prevent reoccurrence. The manager appropriately reported concerns under the safeguarding procedure. For example, we saw that following a medicine audit discrepancies were found in relation to one person`s medicines. This was reported as a safeguarding concern and investigated to ensure the cause of the error was identified, however there were no positive lessons learned for staff to make sure they were aware of how this could be prevented in the future.

Agency staff were not as knowledgeable about safeguarding procedures. We asked one agency staff member to tell us what safeguarding meant to them. They said, "For [people] not to fall away, some of them have dementia so we need to give them assistance." They were unable to describe sufficiently the potential forms of abuse or how they would identify or respond to it. They were not able to tell us how they would raise any concerns either within the organisation or externally. We checked the training records held for agency staff and found that they had received safeguarding training. We asked the acting manager how they ensured agency staff were knowledgeable about safeguarding procedures and how to report concerns appropriately. They told us they had not monitored or tested the competencies of agency staff but instead relied on the training records provided by the recruitment service used. This was an area of concern due to the high numbers of agency staff used at the home.

The provider had a permanent recruitment drive. They were constantly advertising for permanent care staff positions and staff employed had gone through thorough pre-employments checks which included a criminal history check, two references and a full employment history.

At the last inspection we found that people`s medicines were not managed safely. At this inspection we found that improvements had been made about how staff managed people`s medicines. For example, they offered people their medicines in a friendly and professional manner, they were trained in the safe administration of medicines and they demonstrated good knowledge about safe practices.

However we found that where people required medicines to be administered covertly (that is without their prior consent) staff crushed tablets into people's food without having sought the advice of a pharmacist to ensure there would be no adverse effects. We asked a team leader about this who confirmed that an audit had already highlighted this issue which was being resolved in consultation with a pharmacist.

We found that the equipment used in the home, such as wheelchairs, hoists and crash mattresses were clean. There was a cleaning and a maintenance schedule used to ensure all equipment was checked and cleaned regularly in line with the infection control principles. The environment was well maintained and odour free throughout the day of the inspection. This was an area which had improved since we last inspected the service. However not all the equipment people used had been assessed by an occupational therapist or other appropriate person to ensure it was appropriate for people to use. This was an area in need of improvement.

Inadequate

Is the service effective?

Our findings

At the last inspection we found that people`s consent to care was not always sought and decisions made on behalf of people had not always been made following a best interest process. During this inspection we found that suitable arrangements were not in place to ensure that people's consent to care and treatment was obtained in all cases. We also found that the requirements of the Mental Capacity Act 2005 (MCA) had not always been followed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Assessments in relation to people's capacity to consent to care and treatment were not consistently completed. For example we found that for one person several mental capacity assessments were carried out related to washing and dressing, nutrition, changing incontinence pads and some for medication. However for people where staff used physical restraint when assisting them there was no mental capacity assessment specific to this treatment. For example we found that a person had been assessed as needing three to four staff members to turn them in bed due to their unpredictable behaviour. There was no mental capacity assessment, no details about whether the person had consented or any best interest process recorded. There were also no details about what each of the four people should do to ensure any intervention was safe and lawful.

People who were assessed as lacking capacity in making decisions had best interest decisions in place, however these were not a result of a best interest process and they did not take into account views of family and friends involved in the person`s life. One relative told us, "I'd like to know about [person`s] care plans, I'd like [person] to be stimulated, but we don't get invited to reviews we weren't involved in the assessments.

This was a continuous breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities). The provider had not acted in accordance with the Mental Capacity Act 2005.

Some people were restrained in a way that did not always comply with the requirements of the MCA 2005 and DoLS. For example, we saw tables had been placed in front of people restricting their ability to stand up and mobility equipment, such as Zimmer frames, were unavailable or placed out of people's reach. We also saw that three people were physically restrained by staff in circumstances that were both unnecessary and inappropriate. For example, we saw a person assisted to eat by a staff member who sat in front of the person blocking their way out with their body. The person tried to get up and move away but was physically returned to their seat by the staff member at least four times over a period of 45 minutes. Every time the person was pushed back in their chair they said "no", however staff did not acknowledge this and continued to block their way.

We spoke with a nurse and a member of the care staff who both confirmed the practice as usual to assist the person to eat. They also told us the person had gained weight since they had adopted this practice. However, this approach was not documented in the person's care records and staff were not aware of the guidance for this person which detailed, "Reassure with calm and sympathetic manner, leave me to calm down and listen when I say "No"."

We observed another person sitting in a lounge early in the morning. Their Zimmer frame was placed out of reach and a circular table was in front of them. This person was observed to remain in the same chair throughout the inspection. , We observed that they attempted to get up from the chair but were unable to push the table away.

People were assisted to walk with their Zimmer frames and accommodated to sit comfortably in chairs, however their Zimmer frames had been placed out of their reach by staff. Staff told us that they removed the Zimmer frames from people who required assistance to move around the home to prevent them walking when a staff member was not around to assist. However, we found that one person who had their Zimmer frame placed out of reach by staff had been injured after falling when they attempted to get up

and walk by pushing a table out of their way. When we asked staff about this person they told us, "They attempt to walk when we are not around, that's why we take the Zimmer Frame away."

There were no assessments in place about these restrictions, or details about whether the restrictions were in people's best interest. Although the manager made applications to deprive people of their liberty, the applications did not detail the restrictive practices seen during our inspection.

The management team acknowledged that the requirements of MCA 2005 and DoLS had not been followed. They told us they would apply for DoLS but lacked knowledge about how to do so properly. For example, they submitted applications before they carried out mental capacity assessments and best interest decisions to establish the least restrictive method to deprive people of their liberty.

We found that this was a continuous breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems were not in place to establish and effectively report and investigate concerns relating to avoidable harm, abuse or restraint to people who used the service.

People had different views about the quality of the food provided. One person told us, "The food is terrible at times. I have reported this, I am very disappointed." One relative said, "The food is generally ok. They [staff] run out of custard at times or other things but they always go and get somethings else."

People had different experiences of eating, drinking and maintaining a balanced nutritious diet. We observed how people were supported to have a pleasant meal time experience and how they were encouraged to eat on three different units. We found that there were significant differences between these units. People on the unit which cared for people living with dementia were offered visual choices of the main meal and were offered a choice of drink. Staff talked to people as they assisted them to eat and were proactive in noticing if people did not eat well.

However, people on other units although they had a diagnosis of dementia were not offered visual choices; the majority of staff just placed the food in front of them without explaining what it was. We observed food protectors were placed over two people's heads without asking them. . A relative told us a member of the family visited daily to support a person to eat as they lacked confidence in the staff, particularly agency staff.

People were seen struggling to eat at meal times, staff had not provided the right equipment to enable people to eat independently. Specialist beakers were the only equipment used to aid independence. For example, we observed a person who was given a meal of minced meat. While they picked at this with their fingers staff did not offer them a spoon or offer any assistance. The person was left with the same plate of food for 18 minutes, picking at the mince and peas with their fingers. They ate a minimal amount, and the plate was removed.

The person`s care plan noted that they had lost 2.7kg in just over a month and that staff should monitor their food and fluid intake and weigh the person every two weeks. We found that this person`s food an fluid intake had been very small, they normally only managed to eat a quarter of their meals. In the evaluation of their nutrition care plan it was noted, "Always remind [person] to sit down and rest, remind them to eat." Staff were not observed to remind or prompt the person to eat. We observed the person was sat with a table against their legs most of the day of the inspection so they were unable to get up.

We observed another person who sat at a table of four and pushed their food from the plate onto the table cloth. Staff came to assist the person from standing position; they put the food back on their plate and some in their mouth but then walked away. The person again pushed all the food onto the table, staff came back and again simply scraped the food from the table back onto their plate.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not meeting the nutritional and hydration needs of the people.

We found that on the unit where people were living with dementia staff monitored if they had enough to eat and drink and this was recorded in care plans. People were weighed regularly, if it was required, and that when there had been issues, such as weight loss, the staff had sought support and guidance from a dietician. Risk assessments included information to guide staff on how to support people who were at risk of not eating or drinking enough.

Inadequate

Is the service effective?

At our last inspection we found that staff were not provided with sufficient training and not supported to carry out their job roles effectively. At this inspection we found that training for staff had improved. There was a comprehensive training schedule for newly employed staff and also refresher training sessions were provided for other staff members. Newly employed staff told us they had four days induction training before they started working with people. They also shadowed more experienced staff until they felt confident and familiar with the job requirements. Training topics for staff included, manual handling, safeguarding, dementia training, infection control, medication and health and safety.

People and relatives said they thought permanent staff were capable and knowledgeable to meet people's needs. One relative told us, "There are some very good staff who try their best." Another relative told us, "I think the staff are brilliant, it's a shame sometimes that they have the temporary staff as they don't get the same results as the others in helping people."

Staff told us they received supervision every two months and most staff told us they felt supported by the senior staff. One staff member told us, "We have supervision every two months, I don't think is perfect, I have been here a while, I know what I am doing."

People and relatives told us that professionals visited the home to support people`s health needs. One person said, "Staff will call my GP when I want." One Relative said, "They [staff] are good at calling out the GP, very efficient, they arrange [person] dental care and have really helped with that." They continued to say, "If they [staff] do call out the GP and there is something I need to know they tell me straight away." People had regular visits from a hairdresser; chiropodist, dentist and optician to ensure their health needs were met.

Requires improvement

Is the service caring?

Our findings

People praised the permanent staff and also relatives were complimentary about the permanent staff attitude and care towards people however they raised concerns about the agency staff. One person told us, "The staff who work here permanently are lovely, shame they are just a few. Agency staff sometimes have a language barrier and has trouble understanding me. I cannot understand them." Another person said, "Care staff are very nice to me, they come and help when I need them." One relative told us, "I know staff very well they are a lovely bunch but their morale is very low and they all leave."

On the day of the inspection, we observed staff giving care and assistance to people. We found most permanent and agency staff were respectful and treated people in a caring and supportive way. For example, we saw one member of staff supported a person to eat their meal in a dignified way and allowed them to finish eating what was in their mouth before offering more. We observed the nurse at lunchtime administering medicines in a very supportive way by sitting with people and offering them a drink while they took their medicine. However we also observed staff assisting people to eat in an uncaring way, we observed staff talking to each other whilst assisting people with their food and drinks, they made no attempt to talk to the person they assisted, they were ignoring the person.

We observed a regular staff member speaking in a communal area in the hearing of staff, relatives and people using the service explain how one person had been incontinent "I wondered where [person] had gone, [person] wet themselves, I went to find a red bag, when I came back [person] was gone."

Permanent staff told us they had no time to spend with people and they were tired because of the heavy workload. One staff member said, "I think if we had time to communicate and sit with the residents then it would be better. We don't have the time …the agency carers don't know and we have to show them everything." We found staff were task focused, they organised their work around their needs not people`s needs. One staff member told us, "Sometimes other carers wake people because they want them done sooner. I don't think there is anything wrong with that." They continued to say, "We need more staff who are less tired when they come to work. When they are tired it has an effect on the whole atmosphere of the home, they get grumpy, snappy and it shows on their faces."

We observed that staff gave some consideration to people`s dignity and privacy, they knocked on bedroom doors before entering, they closed bedroom doors and put up a sign to alert people that personal care was in progress so they were not interrupted. However we found that on occasions they had not considered all their actions which were not promoting people`s dignity. For example, we observed one person throughout the day of the inspection who was left to sit from the early hours of the morning until late afternoon, without being helped by staff to use toilet facilities. They were assessed as being at high risk of developing pressure ulcers because they had no control over their continence needs and required support of staff to ensure their skin was kept as dry as possible. However staff supported the person to use the toilet at 15:45 in the afternoon and we observed them sitting in the lounge since 07:45 in the morning.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider has not ensured that people were treated with dignity and respect.

Care files and other information about people's medical histories and personal information was kept securely and confidentiality maintained.

Requires improvement

Is the service responsive?

Our findings

People told us they were bored most of the time and there was nothing for them to do all day. One person said, "There's nothing to do, absolutely nothing. I sleep most of the day and watch TV. Even when I want to go out I can`t because there are no staff to come with me." Another person who was bed bound told us, "I watch TV all day that is my only entertainment." Relatives also commented that activities were not offered regularly and there was little stimulation. One relative told us, "My biggest criticism is the lack of activity. [Person name] does say they are bored; it would be good if the staff just played dominoes or cards with them. I'm sure if they took the time [person] would remember how to play something like patience." Another relative said, "Activities are not good. I see very little going on when I visit."

The deputy manager told us that there were three activity coordinators for the home, however one was on holiday and one was absent. They told us the activity coordinators organised events in the home such as regular coffee mornings and trips out for people. However, we found that these were only suitable for people who were able to move around without support. People who could not leave their room had limited activities offered to them; the activity coordinator visited them at most twice a week for a couple of minutes chat.

Staff told us that activities were happening when activity organisers were in, however there were no arrangements in place to cover for their holidays or absence and staff had no time to spare for activities. One staff member told us, "We put music on and sometimes have a little dance and a sing along with people but we don't have time to do more." We found that although a significant number of people in the home lived with dementia there were very limited activities or stimulation available to meet their needs.

We carried out observations on a unit where most people lived with dementia and identified that improvements were needed to provide effective dementia care to enhance people's wellbeing. During our inspection we observed very little meaningful social interactions or activities provided. This showed a lack of awareness of both management and staff awareness of how to support people who lived with dementia. There were no points of interest available, such as photographs or artworks, of a size that could be easily seen.

People had very little person centred information held in their care plans about their likes and dislikes, hobbies and interests. Throughout our inspection, other than watching the TV, we saw no attempts to provide stimulation or meaningful activities for people. For example, an agency staff member based in the lounge to observe people failed to interact with them or enter into conversation. Instead, they completed records and most of the people fell asleep. When staff went into the lounge their interaction with people was very basic, for example, "Are you okay [person], can I get you anything," or "[Person`s name] can I get you a cup of tea." The discussion then ceased and staff talked among themselves.

A person's relative searched a bookcase for a CD, they told a staff member to put on a CD for people, "Something that they may like to listen to." The staff member retrieved a CD, and put it on, but at no point asked people what they may like. The staff member then walked to the TV and turned the volume down, without taking any notice that a person was watching the TV.

Relatives told us that although they had the authority to do so, they were not involved in any care reviews for people. One family member said, "I was never involved in any care planning or reviews. They let me know if something happens." Another family member said, "I was never asked to come for a review, anyway I only have one concern which I told them about. They are getting [person] up very late and sometimes at midday they are eating breakfast and an hour later it is lunch time."

People received care which was not necessarily how they preferred, was not individualised and did not reflect their choices.

We found that this was a continuous breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints were recorded however there was no evidence that they were responded to or thoroughly investigated. We found that complaints were not revisited to ensure a response was sent to the complainant. There were no records to detail the outcome of any investigations into the complaints and how these were solved. The outcomes were not shared with staff and not used to improve the service delivered. For example, one complaint referred to an injury to a person reported by their relative. The incident was referred as a safeguarding concern, the staff member

Requires improvement

Is the service responsive?

was suspended and the wheelchair assessed. There was no response to the family member who made the complaint and no learning outcomes were identified and shared with staff to prevent reoccurrence.

One relative told us that they complained several times about the lack of knowledge staff held about their relative`s condition. They told us, "I complained so many times that staff don't even know [person] has dementia, how can they care for [person] if they don't know their condition." We found no record of their complaints.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to appropriately investigate and respond to complaints and take necessary actions to improve the service.

We saw meeting minutes from recent meetings with relatives where relatives raised similar concerns we found during the inspection. These included: concerns about the high level of agency staff used, permanent staff leaving, staff leaving the communal areas unattended and lack of staff knowledge and skills in meeting people`s needs. We found that the management openly talked about the obstacles they had to overcome to rectify all these issues and they reassured families that they were working hard to raise standards. However when we asked the manager if they had developed a service improvement plan following all the concerns raised by relatives, they told us they had not.

The manager told us they were working on the action plan developed following the concerns and issues CQC and health and social care professionals reported after the inspection carried out on 23 July 2015. We found that the action plan they were working on was comprehensive however it was not covering all the issues raised by relatives which meant that those were not followed up or actioned. For example staff was seen leaving the communal areas unattended was an area which was not monitored by management.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found that there were no robust systems to monitor and improve the quality and safety of the service provided, records not reflected people`s needs and these were not regularly updated. The provider was not monitoring or analysing the high staff turnover or their inability to retain the employed staff. The last inspection also identified that there were no effective systems in place to monitor staff competence and skills to carry out the tasks required of them, and as a result we saw staff practice that placed people at risk of harm. For example, unsafe administration of medication, unsafe use of manual handling equipment, poor risk management. Risks to people`s health and welfare were not assessed, monitored or mitigated.

At this inspection we found that little improvements were made and the service continued to fail to keep people safe.

People's care records were reviewed by staff regularly, however the information contained in them was not detailed enough around people`s mental capacity, mobility needs or person centred care. Daily care records were not completed accurately with unexplained gaps in observation records. The manager carried out regular care plan audits and identified areas in need for improvement, however they had not re-visited the care plans to ensure these had been actioned and improved.

For example, we saw care plan audits which clearly identified the need for records to be updated or improved and the time scale for this to be completed. The audits were detailed and offered guidance to staff on areas they had to work on. However, we saw that most outstanding actions were not completed and the progress to improve was very slow. This meant that the records had not been updated to a standard which gave staff the information they required to care for people safely and appropriately.

The management team had their responsibilities to carry out regular audits. We saw that medicines audits were completed regularly by senior staff. The regular auditing and competency checks carried out by the manager significantly reduced errors and improved the management of medicines for people. The manager requested and external pharmacy audit following issues they identified around medicine administration on one unit.

Incidents and injuries were recorded but the deputy manager confirmed that they were not analysing these for areas such as bruising, frequency of injury, time of day or location. They told us, "I can see why it would be useful to do this, it would help us to see where and why people are falling." Unexplained bruising incidents were not adequately investigated by the management team, even though they agreed that these could be an indicator of abuse, poor care or poor moving and handling, patterns and trends were not assessed and acted upon. Risks were not monitored, reviewed and reduced in an effective way to keep people safe.

This was a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, staff and visitors had mixed views about the management of the home. One relative told us, "The management and even the owner I think have held meetings here. They have told us what is going on, and how they are going to make it better, we attended one of the meetings and were able to freely share our views and ask questions. The important thing was they listened, but in truth not much has really changed since then." One staff member said, "Team meetings are once a month, we talk about everything, how to improve, or for people who require more attention. They continued, "Management are good, there was the one manager who came and left very fast, but the consultant is good and is very supportive. They do the small things that matter like going out of their way to say thank you to us at the end of our shift."

Relatives told us that although things had changed and improved since the previous inspection on 23 July 2015, there were still several areas which needed significant improvement and others where nothing had changed. For example, one relative told us about the lack of activities. They also mentioned that the menus were not varied enough and did not offer enough choices. They told us they wanted to see their relatives care plan; however every time they asked they were told that it was being developed. This meant that the improvements made were at very slow

We asked the management team what had been achieved since our last inspection and what were the management arrangements in the home. We were told by the consultant that there was no registered manager, one was recruited but they left soon afterwards. They said that the provider had taken steps to recruit a new registered manager but at

Inadequate

Is the service well-led?

the time of our inspection the post remained vacant. The consultant told us the interim arrangements were for them to remain as consultant with a remit to make the improvements required by the local authority and CQC action plan. We found improvements were made in medicines management, recruitment processes, training for staff. However we found significant concerns and risks to people in areas like moving and handling, suitability of staffing and risk management.

The management arrangements in the home included an acting manager; the clinical lead was the acting deputy manager and the consultant. The consultant told us, "We feel we have made significant improvements against the safety of the service, and above anything else people are safe here." However we found that people were not consistently safe. They told us that since the last inspection they have encouraged the care team leaders to take responsibility and be part of the leadership group. There were regular 'Heads Up' meetings with team leaders, nurses and managers which discussed every person who lived in the home.

We found that there was a more open culture and transparency regarding incidents and safeguarding referrals. Last time we inspected the service we found that the majority of the safeguarding concerns were identified by external professionals and that the management of the service had no systems in place to identify and report incidents under the safeguarding procedure.

At this inspection we found that systems were in place to record and identify incidents and these were reported to the local authority and CQC, however some of the unexplained injuries and accidents were not thoroughly investigated or preventative measures put in place.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider has not ensured that assessments of the risks to people's health and welfare were carried out, mitigated and reviewed when it was required.** **The provider has not ensured that the staff providing care to people had the competence and skills to do it safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had not ensured systems were in place to establish and effectively report and investigate concerns relating to avoidable harm, abuse or restraint to people who used the service**.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not acted in accordance with the Mental Capacity Act 2005. The best interest process was not followed to ensure the care and treatment people who were assessed as lacking capacity in making decisions received was in their best interest.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The provider has not ensured that they had sufficient numbers of qualified competent and skilled staff to meet peoples` needs safely.
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider was not meeting the nutritional and hydration needs of the people. People who required support to eat and drink were not supported effectively. People`s food and fluid intake was not appropriately monitored.**
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People received care which was not necessarily how they preferred, was not individualised and did not reflect their choices.**
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider has not ensured that people were treated with dignity and respect.**
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider failed to appropriately investigate and respond to complaints and take necessary actions to improve the service.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider failed to assess, monitor and improve the quality of the services provided. People`s care records were not accurately reflecting their needs. The provider failed to assess, monitor and mitigate risks relating to the health, safety and welfare of the people using the service.**