Care Quality Commission

Forest Care Limited

Rowan Lodge

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?	Good
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of Rowan Lodge on 24, 25 and 30 November 2015.

Rowan Lodge is a nursing home for up to 60 older people. When we visited there were 55 people using the service, including people living with dementia. The service is a purpose built nursing home over three floors.

We inspected the service following concerns received about the safety and welfare of people. We found the registered provider had failed to meet the required legal standards of care and welfare for people who used the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service is required by a condition of its registration to have a registered manager.

At the time of our visit a full and effective governance system to monitor the quality of the service and identify the risks to the health and safety of people was not in place. A programme of audits had not been completed and the registered manager had not identified all the areas of concern we had found. Sufficient action had not been taken to improve the quality of care and treatment and ensure the safety of people. The registered manager lacked clarity in their overall responsibility to meet and sustain all the legal requirements of a registered person to ensure the safety and welfare of people.

We found safety concerns in relation to the management of medicines. People had not always received their medicines as prescribed and medicines were not always available when people needed them. The risks of people not receiving their medicines had not always been identified. Systems were not in place to ensure medicine errors would be reported and investigated to prevent them from re-occurring.

When people fell their care plans had not always been reviewed to ensure they reflected the support people required to safely move about in the service. Falls policies did not provide staff with clear guidance on the routine checks they needed to complete to identify and act on any post fall complications.

The rights of people who could not consent to their care and treatment or a deprivation of their liberty were not protected. Decisions about people's care had not been guided by the principles of the Mental Capacity Act 2005 (MCA) when supporting people who lacked capacity. The provider did not meet the requirements of the Deprivation of Liberty (DoLS) safeguards.

People, their relatives and staff gave us mixed views when we asked if they felt sufficient numbers of staff with the necessary skills were deployed to care for people. From our observations there seemed to have been sufficient staff numbers. However, keeping people safe at the current staffing level was not clearly assessed against people's individual support needs or risks. The skills and knowledge required by staff to meet people's needs were not considered in determining the staffing skill mix for each shift. In the absence of an evidence based staffing tool we could not be sure sufficient staff was always deployed to meet people's needs.

Staff had not always received the required training and regular supervision to enable them to always meet people's needs. We could not be sure that all staff would be able to identify signs of abuse or understood their responsibilities under the MCA. Temporary nurses who worked at the service regularly, had not received a thorough induction into the service. Nursing protocols were not always available to nurses to ensure they provided care and treatment in line with current good practice guidance.

The required pre-employment information relating to care workers employed at the home had not always been obtained when care workers were recruited to evidence safe recruitment practices had been followed.

People's care records were not always up to date, accurate or sufficiently comprehensive to ensure staff would have all the information they required to meet people needs, wishes and preferences.

Complaints had been investigated but people could not be assured that action taken in response to their concerns would lead to sustained improvements in the care they received and the service as a whole.

People were supported to stay healthy and the service worked closely with the local GP surgery and other health professionals. We made a recommendation to support the provider to further develop an effective food and drink strategy that addresses the nutritional needs of people using the service.

The provider told us that they had become aware of concerns and shortfalls in the service. They had appointed a new Operations Manager to oversee the quality assurance of the service. She told us she would be completing an assessment of the service as a matter of urgency. The provider has also voluntarily made the decision not to admit people to the service until the required improvements had been made and sustained.

We found seven breaches of the Health and Social Care Act 2008 (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 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 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

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's medicines were not always available when needed and were not managed safely.

People were not always protected from risks to their health and safety. Where people were deprived of their liberty to keep them safe this was not done lawfully.

Recruitment arrangements were not safe. All the information required to inform safe recruitment decisions was not available prior to applicants being offered a job.

A system was not in place to determine the appropriate staffing level and staffing skill mix. We could therefore not be sure there would always be enough staff deployed with the right skills to meet people's needs.

Is the service effective?

Requires improvement 

The service was not always effective.

Staff had not all received the training, guidance and support they needed to enable them to meet people's day to day needs effectively.

The registered manager had not always applied the principles of the Mental Capacity Act 2005 when decisions were made in respect of people's care and treatment. People might therefore not always receive care in line with their best interests.

People had access to sufficient food and drink of their choice. Records did not always provide sufficient information so staff would know how to support people during meal times.

People's health needs were managed effectively. Health professionals were contacted promptly when people became unwell.

Is the service caring?

Good 

The service was caring.

People told us they liked the staff at Rowan Lodge. interactions between people and staff were good humoured and caring.

People were supported to make daily decisions. They could choose how they spent their time, to stay in contact with relatives and practice their faith.

People were treated with respect and their dignity was maintained.

Is the service responsive?

Inadequate 

The service was not always responsive.

Summary of findings

People were at risk of not receiving personalised and responsive care. Care plans did not always accurately reflect people's needs. Instructions to staff in how they needed to support people, where not comprehensive.

Efforts were being made to improve the activities in the service so they would reflect people's hobbies and interests and contribute to a stimulating environment for people.

People and their relatives had opportunities to provide feedback. However, people could not be assured that the service would use complaints investigations to identify shortfalls in the service and use this learning to improve the service for all people.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not established quality assurance and risk management systems to effectively and consistently drive and sustain improvements to the service

Staff did not always understand their roles and responsibilities and these were not clearly defined in the provider's policies.

Rowan Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 24, 25 and 30 November 2015 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us by law.

We did not request a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We obtained this information during the inspection. At the last inspection on 6 June 2014 the service was meeting the essential standards of quality and safety and no concerns were identified.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spoke with five people using the service, five relatives and 17 staff including the registered manager, Head of Care, three nurses, two senior carer workers, three care workers, a domestic assistant, the head of activities, the activity assistant the maintenance person, a kitchen assistant, the cook and the Operations Manager. We also spoke with the provider and a social worker. We reviewed care records and risk assessments for nine people using the service. We also reviewed training records for all staff and personnel files for five staff, medicine administration (MAR) records and other records relevant to the management of the service such as health and safety checks and quality audits.

Inadequate

Is the service safe?

Our findings

During our inspection we observed two nurses administering medicines. We saw they did this correctly; ensuring they had identified the correct person, informed them what medicine they were given and accurately recorded that the medicine had been administered.

However, people had not always received their medicines in a safe and effective way. Prescribed medicines were not always available in the necessary quantities. Seven people had not received their medicine when needed as the service had run out of stock or nurses were not aware new stock had been made available. Nurses had taken action to request more medicines from the GP and pharmacist. However, there had at times been delays in acquiring more medicine. People had missed between one and 15 consecutive dosages and the interruption in their treatment had put them at risk of deteriorating mental health or developing other health symptoms.

Medicine errors had occurred and two people had not received their medicines as prescribed on one occasion as nurses had not followed the prescribing instructions. They were at risk of experiencing side-effects from the additional or omitted dosage. Action had not been taken to identify the risks to people of not receiving their medicine or receiving too much. Plans had not been put in place to prevent people from harm for example, nurses had not increased observations to ensure any risks would be identified and acted upon. They had not checked with the GP whether interim risk management plans were needed to manage people's health until their medicine was received and their treatment was started again.

Medicine storage monitoring arrangements were not safe. Systems in place to ensure medicines were stored at the correct temperature were not always implemented effectively. Daily medicine fridge and room temperatures had not always been recorded. Mitigating action was not always evident when the temperature had risen over the acceptable range to ensure medicines would remain effective.

People were not consistently protected through the effective assessment, identification and management of risks to their health and safety. For example, one person was prescribed Warfarin medicine which thins the blood and can have significant side effects including, prolonged and intense bleeding and bruising. Records showed six incidents of bruising had been identified in relation to this person since 14 July 2015. Their care records and medicine administration records (MAR) did not identify the significant risks associated with this medicine and how staff should monitor for these and address the concerns they may have. Two people were prescribed a variable dosage of Warfarin and required regular blood tests, at specific times, to monitor the safe use of Warfarin. They had not been supported to have their tests done at the time required and there was a risk the dosage they received, when tests were missed, would not be sufficient to prevent the risk of clotting or bleeding. Staff had not received clear written guidance to ensure people administered Warfarin would consistently be protected from the risk associated with this medicine.

Risk assessments detailed some measures to keep people safe from falls, however the risk management plans for people who had fallen, required further development. Staff did not have all the information they needed to support people experiencing recurrent falls to mobilise safely whilst the service waited for other professionals to complete their investigations into the cause of people's falls. For example, incident reports showed one person had fallen eight times between 16 September 2015 and 25 October 2015. However, their care plan had only been updated once to note they had a fall on 25 October 2015.Their care plan did not inform staff that they now used a walker and required ongoing encouragement to use it. The Head of Care told us they had instructed staff to check the person hourly to make sure they were safe. This instruction had not been incorporated in the person's care plans or at daily shift handover so all staff would know how to keep the person safe. Records showed this person had only been checked hourly on 11 November from 9am to1pm. Staff were unsure whether this person still used their walker and whether hourly checks were required. People did not always receive all the support they required to ensure the risks to their health and safety were mitigated

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 Mental Capacity Act 2005 (MCA) The application procedures for this in care homes and hospitals are called the Deprivation of Liberty

Inadequate

Is the service safe?

Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and had applied for the necessary authorisation when depriving a person of their liberty.

The provider did not always provide care and treatment in a safe way to people. They had failed to ensure sufficient quantities of medicines were available and medicines were not managed safely. Risks to the health and safety of people had not always been assessed and all that is reasonable practicable had not always been done to mitigate such risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's rights and liberty had not always been protected when care and treatment arrangements were made to keep them safe. Assessments, planning and delivery of care and treatment had not been carried out in accordance with the Mental Capacity Act 2005 (MCA). For example, the registered manager told us at least six people living with dementia would not be safe to leave the service and required constant support and supervision to keep them safe. Records did not show how it had been decided that it would be in their best interest to live at the service with these restrictions in place. No DoLS applications had been made to ensure the lawful authorisation of these restrictions. People who could not consent to restrictions being placed on them to keep them safe were being deprived of their liberty without appropriate safeguards being in place.

People had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the arrangements in place to ensure staff were recruited safely and people were protected from unsuitable staff. Some recruitment checks, such as proof of applicants' identity, investigation of any criminal record, and declaration of fitness to work, had been satisfactorily investigated and documented. However, none of the five recruitment files we reviewed showed evidence of full employment history. There were gaps in employment history which meant periods of possible employment may be unaccounted for. We found the provider's application form in use did not prompt applicants to provide a full employment history and a written explanation for any gaps. An applicant's employment history could provide information that might make them unsuitable to work with people who use care and support services however, the provider had not gathered this information to support them to make safe recruitment decisions.

We found that the provider had not protected people by ensuring that the pre-employment information required in relation to each person employed was available. This is in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The maintenance person had systems in place to routinely check the environment and the building to ensure a safe environment was provided. This included ensuring equipment and furniture were in working order. If any repairs were required, then this was organised and tended to. Gas safety, electrical safety and water safety checks and maintenance were undertaken by suitably qualified contractors to make sure the premises were safe. Fire safety drills had been completed and the maintenance person had made improvements following lessons learnt from previous drills. For example, the fire evacuation procedure had been re-issued to staff however, the outcome of fire drills had not always been recorded. This meant all staff would not know what action was required to make the next fire evacuation more effective. The registered manager did not routinely check whether all health and safety checks and plans had been completed.

All staff told us they had received training in safeguarding people from abuse and all but one care worker had a basic understanding of the types of abuse which they may observe and how to report this. They felt confident any concerns they raised would be dealt with appropriately by the registered manager or senior care assistants.

The manager was aware of their responsibilities to manage and report any safeguarding concerns to the local authority. The registered manager told us of one incident of safeguarding where he had worked with the local authority to review and address the concerns raised. Whilst we were assured these concerns had been reviewed, apart from information gathering, records did not show investigation of this issue had been thorough and questioning. Comprehensive learning had not been identified from this investigation to improve the reporting, recording and investigation of incidents of bruising in people across the service.

Inadequate

Is the service safe?

People, their relatives and staff gave us mixed views when we asked if they felt sufficient numbers of staff with the necessary skills were deployed to care for people. Comments included ‘‘There is generally enough staff, sometimes they are busier than others’’, ‘‘There used to be a carer in all the communal areas. That doesn’t happen anymore. Staff aren’t visible you have to go looking for them’’ and ‘‘They use a lot of agency staff here, some are getting more familiar recently.’’ The registered manager told us they were actively recruiting nurses and care workers. Records showed 44% of the nursing and 25% of the care workers weekly staffing hours were vacant. The provider used agency staff to cover the majority of these vacant hours. The provider worked with a few agencies and steps had been taken to arrange for the same agency staff to work so that they would become familiar with people’s needs and preferences.

Staff told us although they were busy at times, especially when working with staff that did not know people well, they felt there was sufficient staff to keep people safe. One care worker said ‘‘Staff take their time and don’t rush people even if they are really busy.’’ The Head of Care explained the arrangements made when the service had unplanned staff shortages and one care worker told us ‘‘When we are short staffed we jiggle things around’’.

We asked the registered manager how the staffing levels for each shift was determined. They told us ‘‘It has been historical, we inherited these staffing numbers and have continued to staff at this level’’. The registered manager gave us some examples of how staffing levels had been increased at times to ensure people’s deteriorating health needs would be met.

From our observations there seemed to have been sufficient staff numbers; for example, we did not notice any people being left waiting to be attended to, and on the occasions when we heard the call alarms being sounded these appeared to be responded to quickly. The people we spoke with said that staff would always respond to any requests for attention, However, the service did not have a system or recognised staffing tool in place to routinely determine, record and review their decisions about staffing levels. Keeping people safe at the current staffing level was not clearly determined by people’s individual support needs or risks, or the skills and knowledge of staff meeting people’s needs. If people’s needs changed or a number of staff that did not know people well worked the same shift, staffing levels and skills may not be d sufficient to meet the increased need. In the absence of evidence based staffing tool and what people told us we could not be sure sufficient and suitably skilled staff were always available to meet people’s needs.

Requires improvement

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA when making decisions about people's care and treatment.

The registered manager told us some people who lived at the home had capacity to make decisions on a day to day basis. Where people had capacity to consent to their treatment, we observed staff sought their consent before care or treatment was offered. However, care plans and consent forms in people's care records were incomplete, had not been signed by the person or their legal representative and in some cases had been signed by a relative. For example, one person's relative was their legal representative but had not signed their bedrails care plan. One person's care plan for hourly safety checks and another's person's consent form for photographs, medicine and personal care had been signed by a relative. There was no supporting information available to show why these people had not given their consent and relatives had done this for them. There was no evidence that these decisions had been agreed at a best interest meeting or whether the relative was their legal representative. There was a risk people who could not consent to their care arrangements would not receive care and treatment in accordance with their wishes and rights under the MCA

Care and treatment of people was not always provided with the consent of the relevant person. Where people were unable to give such consent because they lack capacity to do so, the provider did not act in accordance with the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with confirmed they had completed an induction and undertaken training to enable them to undertake their roles competently. Comments included 'We get a lot of training'' and ''They are really encouraging us to do our training''. Records however, showed staff had not all undertaken a range of training in areas considered mandatory by the provider. For example, not all staff had completed dementia, safeguarding, person centred care, MCA and DoLS training. Not all staff we spoke with understood the principles of the MCA and their responsibility under the Act. We could not be sure that all staff had the knowledge and skills required to meet people's needs appropriately.The manager told us he was working with staff to ensure they were trained to an appropriate level to meet the needs of people however, he could not give an indication as to when the outstanding training may take place.

The registered manager had re-introduced a system to support staff development through the use of one-to-one sessions of formal supervision and appraisal in July 2015. Records showed 17 staff members had received supervisions since July 2015. However, improvement was still needed to ensure all staff would receive six supervision sessions per year in line with the registered provider's policy. Regular staff meetings took place and staff told us this provided an opportunity to raise concerns and reflect on their practice.

Induction, supervisions and support arrangements were not sufficient to enable agency workers to fulfil the requirements of their role. The registered manager had reviewed the induction for agency nurses and was taking agency nurses through the induction again if they had not completed the induction. The induction however, did not provide agency nurses who worked regularly at the service with sufficient support and information to enable them to carry out their duties. For example, agency nurses told us they were not clear on their recording, observation and reporting responsibilities. They did not know the procedures to follow if medication errors were to occur or if people were to become unwell or the provider's requirements for post falls observations. The induction and providers' policies did not provide agency nurses with this information. Formal supervision arrangements were not in place for agency nurses and agency care workers who worked regularly at the service to ensure they could demonstrate they maintained the required levels of competency to carry out their role effectively. Comprehensive operating procedures were not always available to agency staff to support them to provide care and treatment to people in line with good practice requirements.

Requires improvement

Is the service effective?

Staff did not always receive appropriate support, training and supervision as is necessary to enable them to carry out the duties they are employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received nutritious food and drink in line with their preferences and needs. We observed the lunch time meal and food was fresh, homemade and wholesome. People were satisfied with the food provided and always had enough available to eat and drink. They were offered a choice at each mealtime and the catering staff had a good awareness of people's preferences. Alternatives were available if people did not want the meals on offer. One person was offered an omelette when they declined the lunch meal which was cod or pasta bake. Special diets were catered for such as soft, enriched, pureed and vegetarian diets. People's dietary requirements and allergies were displayed in the kitchen so catering staff would know what food to prepare. Kitchen assistants asked people daily what meals they would like and took the information relating to people's dietary requirements with them to ensure they could support people to make appropriate meal choices.

People at risk of weight loss had been identified and weighed monthly. Guidance had been sought from the community dietician and Speech and Language Therapist (SALT) to support people at risk of malnutrition and swallowing difficulties. Staff could describe the action taken to ensure people at risk received sufficient nutrition including offering regular small amounts of food, sitting with people during mealtimes and encouraging people to eat. Care records however, did not always include this guidance to ensure all staff would know how to consistently provide people with the required support.

Weight records had not always been scrutinized so nurses would be assured they had accurate information to inform their investigations and action to address weight concerns. For example, records showed one person had gained 10.4kg in seven months and another had lost 10kg in six weeks. We asked the Head of Care if these weights were correct. She told us these seemed excessive but could not describe what action had been taken at the time to check if the information in people's weight records were correct. People might not have received the support they needed because staff might not always have accurate information to inform their care decisions about people's nutrition and care plans did not tell staff what mealtime support people needed to remain nourished.

We recommend the provider seeks advice and guidance based on current best practice from a reputable source in relation to the implementation of an effective food and drink strategy that addresses the nutritional needs of people using the service.

There was evidence of health and social care professional involvement in people's individual care on an on-going and timely basis. This included support from podiatry and physiotherapy visits as well as mental health input. People were supported to attend their hospital appointments. People benefited from regular health reviews and a local GP routinely visited the service every Thursday. Nurses identified people at need of health input and faxed a list to the local GP every Wednesday to highlight people that required medical input. Staff gave us examples of how they had supported people who were anxious to have medical procedures done and how they worked with health professionals to find solutions when people refused treatment to ensure people's health needs would be met.

Good

Is the service caring?

Our findings

People told us they liked the staff at Rowan Lodge. People's comments included, ''Everyone is very friendly and very kind to me'', ''They treat me very well'', ''Staff are lovely'' and ''Staff speak nicely to people''.

Interactions between people and staff were good humoured and caring. Throughout the inspection, staff showed care and concern for people's wellbeing. People appeared relaxed, comfortable and responded positively to staff when asked what they wanted to do or eat. Staff gave people time to respond to their questions and told us they used short sentences and flash cards to support people to make their meal choices. We observed a kitchen assistant asking a person's relative what they thought a person would like for lunch when they struggled to make a decision.

People were encouraged to be as independent as possible and were involved in making decisions about things that affected them. For example, people were encouraged to manage their personal hygiene and appearance. Staff told us they respected people's wishes on how they spent their time and the activities they liked to be involved in. When people chose to spend time in their rooms we saw people's tables were near them and their glasses, remote controls and books were within easy reach. People had been involved in decisions about the décor of their rooms and were surrounded by objects they held dear.

We observed laughter and banter between people and staff. The language heard and recorded in care records was appropriate and respectful. Staff used touch to support people to understand instructions, we saw this was done appropriately and people seemed comfortable and reassured through physical contact with staff. Contact was unrushed, with smiles and kindly gestures, such as when asking where people would like to sit or when people appeared not to understand what was asked of them.

When people became upset we observed staff promptly noticed their distress and offered reassurance and comfort. For example, some people could not remember when their visitors were due and staff reassured them calmly and patiently reminded them of the time. We saw this reassured people. Staff who knew people understood what could potentially upset people and took action to prevent these situations from occurring thereby supporting people to have a good day. For example, ensuring people sat on their favourite chair, had someone to chat with or gave people information throughout the day so they did not become anxious if they could not remember what was going to happen.

Family and friends were encouraged to visit whenever they wanted and staff supported people, who wanted to have regular and frequent contact with relatives. People's faith needs were respected and a monthly Christian church service and communion was held at the home.

Staff explained to us that an important part of their job was to treat people with dignity and respect. Our observations confirmed that staff respected people's privacy and dignity. Staff used people's preferred names and spoke with them in a kind and patient manner. We observed new staff being introduced to people when the need arose. If people required support with personal care tasks this was done discreetly, behind closed doors to ensure their dignity was maintained.

Inadequate

Is the service responsive?

Our findings

Agency staff were reliant upon the daily handover sheet to understand people's care needs as they said they had not always had time to read people's care plans or risk assessments before starting to care for them. The version of the handover sheets the staff were using on 23 November 2015, the first day of the inspection, was not dated for the lower ground floor. They contained the names and information of people that no longer lived at the service. The first floor and lower ground floor handover did not have the section relating to 'Diet Type' completed and information about people's medical conditions were not complete and did not for example, include information about people's wounds. This placed people at risk of not having their needs recognised or met.

The registered manager recognised the care plans did not consistently provide sufficient information about people's care needs and the support they required to meet their needs. He had been working with staff to update people's care plans. However, some we looked at still needed to be updated and did not have sufficient detail to enable staff to understand the care and support needs people had. For example, one person's care plan stated they were unable to make their own decisions and in another section noted they "continue to be supported to choose their own meals." This person could not say if they were in pain and "staff had to look for non-verbal clues". There was no explanation of what it was like for this person to be living with dementia, how staff were to enable their decision making and what non-verbal clues might indicate they were in pain. A care worker who knew this person well was able to describe how they would support this person to choose their meals and identify if they were in pain. Care plans however, did not provide staff, who did not know people, with sufficient information to ensure people would receive their care and treatment in line with their preferences, wishes and needs.

Care plans did not always included sufficient information on how staff were to support people to meet their emotional needs. For example, one person whose behaviour might put themselves or others at risk, required the use of medicine when they became agitated. Care plans did not indicate how nurses would know when this medicine was required and how to monitor for side effects or identify if further medicine was needed. Care plans did not include what action should be taken to try and support the person before medicine was administered Sufficient information was not available for nurses to know how to support each person to manage their anxiety and agitation.

People's daily care records were not always completed to inform nurses that the care they had instructed care workers to deliver had been provided and people's needs had been met. For example, one person required regular engagement in activities to support them to remain calm. Their social activities record had not been completed since May 2015 and it was not evident from this record whether they had received their support. Two people had been assessed as requiring assistance to undertake personal care tasks. There were gaps in their personal care records and we could not be sure they had received the support they required to meet their personal hygiene needs. Care plans had not always been reviewed each month. People and relatives gave us mixed views about their involvement in care planning. Records did not always show whether people and their relatives had been involved in reviewing their care needs and how they wished to be supported.

The provider had not always maintained an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to each person and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Structured activities were available for people every day and they were able to choose whether they wished to join in or not. The Head of Activities told us the activities programme was displayed in the service and emailed to relatives. A shoe company and clothing company had visited the service so people could do their shopping in the comfort of their home, residents enjoyed a touring cinema and visiting music workshop and a reflexologist visited the service every two weeks. Activities for the men used to include a visit to the local pub but since the pub closed in the summer the activity team have set up a pub afternoon in the service. The Head of Activities said "The men love it, they have a beer and everything is just like the real thing".

Events were held throughout the year and relatives were encouraged to take part in celebrations and events at the service. People and relatives gave us mixed feedback about their satisfaction with the activities. One person told us 'They rarely interest me except for when the small animals

Inadequate

Is the service responsive?

come in, I like that and going to the pub'' and a relative said ''She gets no stimulation or activities''. People had indicated in the resident survey in August 2015 that they would like to see some improvements in relation to the activities on offer. The registered manager had introduced weekly activity team meetings and was taking action to improve activities to reflect people's preferences. This included re-introducing the previous activity staffing arrangements that relatives and people had said they preferred.

People and their relatives were given the opportunity to provide feedback about the service. They received a monthly newsletter informing them of any changes in the home and a copy of the next month's activity plan so relatives had information to ask people about their day. A quarterly residents and relatives meeting took place. This informed people and relatives of any staff changes and was an opportunity to raise concerns or provide feedback about the quality of the service. The registered manager told us the tea trolley had been reinstated when relatives expressed concerns that people might then not get enough to drink when formal tea rounds were stopped.

The provider had a complaints policy and people and their relatives received a copy when they moved into the service. People and relatives told us they had some concerns about the service. They had discussed these with the registered manager and he had offered to meet with them to discuss their concerns. The registered manager told us they had received six complaints in the past year and some of these were similar to the concerns people had shared with us. Records showed that he had conducted investigations into the complaints and other concerns received.

Though we could be assured that the provider had investigated people's concerns with their input, and had taken action to put it right, we were not sure the action would result in sustained improvement. The provider had not used the information gained from complaints to drive service improvement, practice had not always changed, or changes made to people's care plans to ensure any failures identified would be monitored over time. For example, we discussed the outcome of a complaint provided in February 2015 assuring the complainant that all nurses working in the service would be trained and competent to use the service's syringe driver. The Head of Care told us at the time of our inspection not all nurses were competent to use this equipment and support from the Community Matron would be required if a person required the use of this syringe driver. People could not be assured that the service would use complaints investigations to identify shortfalls in the service and use this learning to improve the service for all people.

The provider did not operate an effective system for responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in place. 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. The registered manager joined the service in April 2015 and registered with CQC in September 2015.

The registered manager did not always understand and implement the principles of good quality assurance to drive improvements. The registered manager and provider were aware of the need to develop good nursing practice at the service. However, systems were not in place or effectively operated to support the registered manager and staff to continually evaluate the quality and risks in the service. They had identified some concerns in relation to care plans and medicines but had not identified all the concerns we found and the risks these could pose to people's health and safety prior to our visit.

There was no formal system to assess and monitor the levels of staffing required. A dependency tool was not used to monitor the level of support people required to ensure there were sufficient staff on duty at all times to meet people's care needs and manage the home. This impacted on the service's ability to be proactive in identifying risks and areas for improvement.

The safety incident reporting system was not comprehensive enough to ensure the registered manager would be informed of all incidents that could indicate people's health and safety were at risk. For example, there was no formal system for staff to report when a medicine error occurred or equipment failed. When the registered manager had become aware of these incidents they had not reviewed the safety reporting system to ensure it incorporated all the potential risks in the service. Staff's response to safety incidents could therefore not always be monitored so that so that swift action could be taken to keep people safe if needed.

Quality audits were not always being consistently carried out. Checks were not in place to ensure the registered manager would identify shortfalls in the service's infection control practices and the safe use of equipment. For example; the syringe driver and nebuliser used by the service, were not checked routinely to ensure they remained safe for use. There was an incident in September 2015 when the service's nebuliser failed and they had to source one urgently from the GP surgery. At this inspection checks were still not in place to ensure equipment would remain in working order so as to be readily available when people needed it.

Information from audits had not been used to effectively drive improvements. A service audit had been completed in August 2015 and identified some of the concerns we found in relation to care plans and medicines. The Head of Care had met with the nurses on 1 September 2015 and 29 October 2015 to discuss and agree a plan to address the care plan concerns. However, improvements for example, in relation to updating people's care plans and providing personalised information on how staff were to meet people's dementia needs, had not consistently been made. We continued to identify similar recording concerns at this inspection. The registered manager could not tell us what action had been taken to address the medicine concerns noted in the August 2015 audit. Daily medicine stock audits had been introduced in October 2015 but these had not been completed consistently. Action taken to improve quality ad not always resulted in the required improvements.

Another medicine audit had been completed following concerns in November 2015. However, this audit had not identified all the concerns we found. The reason for the gaps identified in MARs had not been investigated and recorded in the audit and the registered manager would not be able to tell from the audit if it related to a recording or administrating concern so that the action plan would be appropriate in addressing the risk. Audits undertaken had not always been effective and reliable in identifying and understanding shortfalls and people might be at risk without the provider being aware.

The service policies did not always support staff to know what current best practice looked like so they would be able to assess whether people had received care and treatment in line with current quality and safety standards. The registered manager did not always keep up to date with current practices and did not regularly update the service policies to reflect any new practices that might have been introduced. For example, the service did not have a diabetes policy that reflected current guidance so that staff

Is the service well-led?

would know people whose diabetes was well managed with medicine, did not always require a restricted diet. A policy was not available to inform staff how to safely care for people identified as at risk of experiencing seizures. The service's falls policy instructed staff to continue to observe people following a fall. The Head of Care told us it would be best practice to observe people hourly for 24 to 48 hours after a fall. This timescale had not been incorporated in the falls policy and nurses told us they did not know how often and for how long the provider required them to continue with their observations. The policy had not instructed nurses on where to record their post-falls observations and we saw this was not done consistently. In the absence of clear guidance and working protocols staff might not always know how to consistently provide quality care, monitor each other's practice and identify when people's care fell under an acceptable standard.

A robust clinical governance system to review and inform nursing decisions was not being operated to monitor if nursing care was being provided in line with good practice standards. Though the Head of Care told us they routinely reviewed all wound treatment plans, the outcomes of these reviews had not been written down. Nurses did not have a record to refer to when making ongoing treatment decisions to ensure their work would consistently reflect best practice. The number of hospital admissions, falls, wounds and infections were collated and sent to the provider every month. However, the registered manager had not worked with the Head of Care to use this information to identify shortfalls in practice so improvements could be made that would benefit future treatment of all people in the service.

Recording systems had not been operated effectively to support quality monitoring. For example, Medication Administration Records had gaps where you would have expected to see a signature or a code indicating the reason medicines had not been administered. Medicine records did not support the provider to monitor medicine practices as they could not judge from the MARs, whether people had received their medicine as prescribed.

People's medicine records were not always maintained securely. During our inspection we found completed MAR sheets were kept in an open box under the desk on the first floor and records were left open and unattended on a medicine trolley. This meant people's confidential information was not held in accordance with the requirements of the Data Protection Act 1998.

The provider did not implement robust quality assurance systems to assess, monitor and improve the quality and safety of the home. People's records had not been maintained securely. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that they had become aware of some concerns and shortfalls in the service. They were concerned that the quality of the service had not been audited routinely, they had to deal with some complaints and were concerned that checks were not in place to prevent incidents from occurring. They had appointed a new Operations Manager who told us she will be completing an assessment of the service as a matter of urgency. The provider has also voluntarily made the decision not to admit people to the service until the required improvements had been made and sustained.

Staff told us they experienced the leadership in the service at times to be weak or inconsistent. Staff gave us mixed views on the registered managers' visibility in the service and their understanding of clinical concerns. Temporary nurses did not always feel supported in their role as decision makers. We heard examples of care workers asking for guidance in relation to people's treatment plans from senior care workers or the head of care instead of the nurse on duty. Some care workers told us the temporary nurses working regularly at the service were developing an understanding of people's needs but they were not always confident that all the nurses would know what people needed. Staff did not have a clear understanding of their roles and in the absence of clear nursing governance and working protocols nurses found it difficult to fulfil their roles with confidence.

Communication had not always been effective. Relatives gave us examples of how their concerns had not been shared with all staff and how they had been given incorrect information when incidents had occurred. There had been incidents when communication about people's end of life wishes had not been understood by all staff.

The registered manager told us when they joined the service they had concerns about the culture and described

Inadequate

Is the service well-led?

it as having been ‘‘A place were staff did not always feel comfortable to raise concerns, there was not a strong sense of team working and staff struggled at times to take responsibility for their mistakes and a blaming culture had developed’’. They had introduced team meetings to keep staff members’ values under review and told us staff were beginning to display the right values and behaviour towards people. Action had been taken to address concerns through the disciplinary process when appropriate. Staff told us the culture in the service had improved and comments included ‘‘It is getting better, we all feel like a team’’, ‘‘We support each other more’’ and ‘It is beginning to feel like a family’’.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had not protected people by ensuring that the information required in relation to each person employed was available. Regulation 19 (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of people was not always provided with the consent of the relevant person. Where people were unable to give such consent because they lack capacity to do so, the provider did not act in accordance with the MCA. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not always receive appropriate support, training and supervision as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not operate an effective system for responding to complaints. Regulation 16 (2)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users had been deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that medicine administration was safe. People did not always receive their medicine in a timely way, medicine errors had occurred and medicine was not stored safely. The provider had not ensured risks to people's health and safety was always assessed and action taken to mitigate these risks. Regulation 12 (1) (2) (a) (b) (f) (g)

The enforcement action we took:
We issued a Warning Notice and told the provider and registered manager to make the required improvements by 29 April 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that systems and processes were established and operated effectively to ensure the service; assessed monitored and improved the quality and safety of the service provided and assessed, monitored and mitigated risks relating to the health, safety and welfare of people who used the service and others. The provider did not maintain securely and accurate, complete and contemporaneous records for each person, including a record of the care and treatment provided. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:
We issued a Warning Notice and told the provider and registered manager to make the required improvements by 29 April 2016.

This section is primarily information for the provider

Enforcement actions