Hooklands Limited

# Hooklands Care Home with Nursing

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

The inspection took place on 24 and 26 January 2017 and was unannounced.

Hooklands Care Home with Nursing provides accommodation for up to 27 older people who require nursing or personal care. At the time of our visit, there were 20 people in residence. The service is located in Bracklesham Bay and the garden backs onto the sea. Communal areas include two lounges and a dining area. There is a lift to access bedrooms on the first and second floors. The new provider was investing in the service and had made improvements to the fabric of the home and garden. Adaptations were also planned to make the home environment more suited to people living with dementia.

The service did not have a registered manager. A new manager had been appointed in October 2016 and was in the process of registering with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People, relatives and staff spoke highly of the service and the kindness of the staff team. We found, however, that there were no systems in place to monitor the quality and delivery of the service in order to ensure that people received safe care.

The service was not safe. People were at risk of receiving inappropriate care or treatment because risks to their health, safety and welfare had not been assessed or managed consistently.

There was no system in place to ensure that medicines were managed safely and the competency of staff administering medicines had not been checked.

New staff had started working in the home before the necessary recruitment checks had been completed.

The service was not always effective. Some staff had not received necessary training to enable them to provide effective support to people. Although staff felt supported, they had not received recent supervision or an appraisal of their performance.

Where people lacked capacity to make decisions relating to their care and treatment, staff did not understand or put into practice the requirements of the Mental Capacity Act 2005 (MCA). This meant that people's wishes and rights may have been overlooked.

People were not fully involved in planning and reviewing their care. There was limited information about their future wishes and no evidence of their involvement when significant changes occurred. We have made a recommendation about involving people to ensure their care is appropriate and reflects their needs and preferences.

The service was not always responsive. People's care plans did not always reflect their current needs and monitoring records about their care were incomplete. Although staff knew people well, there was no system to ensure staff would identify or know how to respond to changes in a person's health.

People felt confident to raise any concerns with staff and told us they knew how to complain. Following our inspection, the provider updated their complaints policy to ensure that clear information was displayed and available to people.

The service was not consistently well-led. The manager and provider knew the service needed to improve but there was no system to identify areas of concern or a clear plan of action as to how and when known issues would be addressed.

Due to our concerns, we shared our findings with the local authority safeguarding team and the West Sussex Fire and Rescue Service.

People told us the staff were caring. There was a regular team of staff at the home, which helped to provide continuity for people. In one card of thanks we read, 'Thank you all for looking after me so beautifully. It was the happiest place to be when I needed the extra nursing care'. In the provider's survey one response read, 'The staff are more like friends and family than carer, nothing is too much trouble'. People were treated with dignity and respect.

Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse.

People enjoyed the food and were offered a choice of meals.

Where appropriate, referrals were made to healthcare professionals, such as the GP, dementia crisis team or Tissue Viability Nurse (TVN). A nursing healthcare professional told us that staff were good at seeking and following advice.

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

## 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 at risk of harm because risks to their safety had not been properly assessed or managed.

There was a lack of training and guidance with regard to medicines. The system in place did not ensure that people received their medicines safely.

Pre-employment checks had not been completed for new staff before they started work.

There were enough staff to meet people's needs.

The home was clean but staff were unaware of policies in some areas and there were no checks in place to ensure and promote safe practice.

Staff on duty understood how to identify abuse and described the action they would take in response to safeguarding concerns.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People's rights under the Mental Capacity Act 2005 were not supported because staff lacked understanding of this legislation.

Staff had not received appropriate training, supervision and appraisal to enable them to carry out their duties effectively.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

The premises were being improved by the provider and adaptions were planned to make it easier for people living with dementia to orientate themselves within the home.

## Is the service caring?

Requires Improvement

The service was not always caring.

Although the service was caring in many respects, people were not fully involved in making decisions relating to their current and future care preferences.

People received individualised care from staff who cared and who knew them well.

People were treated with dignity and respect.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

There were inconsistencies in people's planned care and a lack of monitoring to ensure that their needs were met.

Staff understood how to support people but there was no system in place to ensure they responded quickly and appropriately to changes in a person's health.

People enjoyed one to one time with staff and were able to participate in limited activities.

People were happy to raise any concerns with staff and felt confident any issues would be addressed. People knew how to make a complaint if necessary.

## Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were no systems in place to monitor the delivery of care that people received and ensure that it was consistently of a good standard.

There was no plan in place to manage the improvements needed in the service and to ensure they were delivered.

People and staff spoke highly of the manager and provider. Staff were felt they were listened to and valued.

The culture of the service was open and inclusive. People and staff felt able to share ideas or concerns with the management.

# Hooklands Care Home with Nursing

**Detailed findings**

## Background to this inspection

This inspection took place on 24 and 26 January 2017 and was unannounced.

One inspector, a specialist advisor in nursing and dementia care and an expert by experience undertook this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience at this inspection had expertise in caring for older people.

Before the inspection, the former registered manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed feedback and concerns received from relatives regarding the service and notifications received from the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We looked at care records for six people, medication administration records (MAR), monitoring records, accident and activity records. We also looked at three staff recruitment files, staff training and supervision records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with five people using the service, three relatives, the manager, one registered nurse, one agency nurse, five care assistants, the kitchen assistant, the person in charge of maintenance and the provider. We also met with a nursing healthcare professional who was visiting the service and asked them for their views. Following the inspection, we telephoned the activities coordinator to find out more about the activities programme. We also received feedback from a nurse assessor who had involvement with the service. They consented to share their views in this report.

This was the first inspection of Hooklands Care Home with Nursing since a new provider took over the service in March 2016.

Inadequate

# Is the service safe?

## Our findings

Risks to people were not managed consistently or safely. Risks had not always been reviewed or assessed correctly and the monitoring of people's health and condition was often ineffective. This meant staff may not have taken all reasonably practicable action to minimise the risks to people.

People's risk of developing pressure areas had been assessed using Waterlow, a tool specifically designed for this purpose. We found that staff had not used the tool consistently to calculate the risk to people. For example, following the assessment, the same resulting score had been logged as 'at risk' and as 'at very high risk'. There was no clear guidance for staff as to what the result of the assessment should mean for the care and support for the person. Despite the lack of clarity in the assessments, staff used pressure relieving equipment such as mattresses and cushions to minimise the risk to people. Mattresses were checked by staff to ensure they were set correctly according to the person's weight. We found, however, that people who needed help to change their position may not have received appropriate support. There was no written guidance for staff on how often a person should be supported to change their position and the intervals recorded ranged from two to more than five hours. In two of the records we viewed, each 'change' of position was recorded as the person still lying on their back, rather than supporting them to move to their side for example. This would not provide effective support to minimise the risk of developing a pressure injury.

Records relating to wound care lacked detail and were often inaccurate. This put people at risk of receiving inappropriate care and treatment. One person had leg ulcers which were dressed by the registered nurses. Information in the care plan referred to a specific condition and provided guidance to staff on how to treat this. On further investigation, we learnt that this person did not have this condition and that the information was incorrectly stored in their care plan. The treatment being provided to this person was not the conventional treatment for this type of wound. Staff told us that the person had refused the recommended treatment but there was no record of this or of the discussion having taken place. The care plan for the ulcers stated that photographs should be taken monthly to assess healing. We found just one set of photographs in the records and limited written information as to the size of the wounds and how they were healing. The documentation was muddled making it difficult to understand the support provided. We noted that staff had made a prior referral to the Tissue Viability Nurse (TVN) and were awaiting advice on how best to support this person.

People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The provider had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. We found, however, that this tool had been used inconsistently and that there was little evidence of action following the result of the assessment if it showed a person to be at risk. One person had lost just over 4.5kgs between October 2016 and January 2017. Their MUST was last completed in October and showed a medium risk. We calculated their score using their weight from January 2017 which resulted in high risk. There was no evidence that staff had repeated the assessment or noted the weight loss. There was no care plan describing the support staff should provide to this person in relation to their nutritional needs.

The manager showed us the information they used to review people's weight. This covered a period of three to four weeks and did not show the long term trends. This, added to the irregular reassessment of risk, meant there was no system to pick up when people were losing weight. We asked staff working in the kitchen how they were informed about people who were losing weight. They showed us a list of dietary needs, which included a prompt for 'increasing diet'. They explained they would fortify food and offer additional snacks to boost the person's calorie intake. We found, however, that the information available to them was dated August 2016 and did not include all current residents of the home. There was no detail regarding the person referenced above in terms of dietary needs or weight loss concerns.

Staff maintained fluid charts for everyone at the home. A fluid chart is used to ensure that people are drinking enough to maintain their health and for staff to be alerted if a person has not had enough to drink. We found, however, that there was no target fluid intake recorded for people and no guidance for staff on when or what action to take if a person had only drunk a little during the course of the day. Some of the charts showed a low fluid intake, for example one person had only drunk 625ml (the recommended daily intake for older females is approximately 2000ml). The system in place was fragmented as records were made in the dining room and in people's bedrooms. There did not appear to be any oversight to review the records in place or to take action to ensure people were protected from dehydration.

Where people were supported to use the toilet, staff maintained a record of their bowel movements. This should help to ensure their well-being and enable staff to take action such as giving prescribed laxatives if a problem occurs. We looked at the bowel monitoring charts and found unexplained gaps of up to five or six days. In some cases we found entries in the daily notes relating to bowel movements, but this did not account for all of the gaps. There was no evidence in the care plans that people's risk of constipation had been assessed, or guidance on what action staff should take if they did not have regular bowel movements. Therefore it was unclear how people's bowel health was being monitored and responded to when changes arose.

Some people who lived at the home presented, on occasion, with behaviours that challenged. Care plans directed staff on the actions they could take to reassure the person and keep them safe. For example, they were advised to talk to the person about particular topics of interest to them, use written communication as the person had limited hearing and to liaise with other healthcare professionals. Staff told us they kept a record of incidents involving people who were known to present with specific behaviours. We looked at the daily records for one person and noted recent incidents, including shouting and biting a care assistant's finger. We looked to see the corresponding entries on the behaviour charts and found these blank. This would make it difficult for staff to identify any patterns in behaviour or to determine what triggered the person's anxiety. This meant that people may not have received appropriate support which put them and the staff supporting them at increased risk of harm.

We asked staff about the action they would take to respond to a variety of emergency situations, including for resuscitation, choking and evacuating the building. The home had first aid kits and the contents were in date. There were also airways to assist in giving breaths if a person needed resuscitation. The registered nurse on duty was unable to explain how to use these airways correctly. We noted from the training records that they had not attended first aid or basic life support training. The incorrect use of this equipment could put people at increased risk. Staff were also unclear on the action to take in the event that a person choked in bed. As many people were cared for in bed and ate their meals in bed, this could present a risk that people would not receive effective support in a timely manner. We looked at the procedures in place to evacuate people in the event of an emergency, such as a fire. We found that evacuation plans were missing for some people. One person had moved in four months earlier, in September 2016, and still did not have an evacuation plan in place.

The lack of action to effectively assess and mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also noted good practice in relation to risk management. We observed staff safely supporting people to transfer using equipment such as walking frames and hoists. Staff offered reassurance and guidance to the person, ensuring that they were comfortable and calm throughout the process. Some people used lids on their hot drinks to prevent the risk of spills and scalds. Staff told us about one particular person who did not like to use a beaker. The purchase of the lid had enabled the person to continue using a cup and saucer whilst minimising the risk to them.

People were at risk because systems to manage medicines were not operated safely. Medicines were administered by registered nurses but no training had been given and the competency of individual staff members had never been formally assessed. We found that a medicines error on the first day of our inspection had not been reported, neither had staff contacted the person's GP to check what action should be taken to ensure the person's wellbeing. The home had a stock of homely remedies but there was no written guidance available to staff on their use. The registered nurse on duty was unable give an example of when each of the medicines would be given. There were no checks or audits in place to reconcile the stock with the administration records and ensure that medicines had been given as prescribed.

Medication Administration Records (MAR) were complete. We found however, that topical creams were administered by the care staff but signed for by the registered nurses. There was no system in place for care staff to communicate to the nursing staff when creams had been applied. This meant the records may have been inaccurate and there was no assurance that topical creams had been applied in accordance with the prescriber's instructions. When a person refused their medicine, this was documented on the MAR. We asked the registered nurse what action they would take if a person kept refusing. They told us that they would try to encourage them but the nurse was not sure how many refusals they should leave before reporting the matter. We identified two people who received their medicines crushed and mixed with custard. We were advised this practice was to aid the person's ability to swallow the medicine. The care plans stated, 'Discuss with pharmacist if medications are safe to crush and not compromised by doing so' and 'Obtain authorisation from GP and pharmacist to crush the medications, and record'. Whilst the GP had signed the care plans, there was no evidence that staff had checked with the pharmacist to ensure the medicines would remain effective when crushed or any instructions about mixing the medicine with food. This could put the person at risk if the treatment was rendered less effective.

Medicines were not managed properly or safely. There was a lack of guidance for staff and an absence of checks to ensure safe management. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of medicines management were safe. Medicines were stored appropriately, including those that required refrigeration. Medicines for disposal were recorded and collected from the home. We observed staff administering medicines to people. This was done calmly and staff remained with the person to ensure the medicine had been taken before signing the MAR. The manager explained that they were in the process of changing pharmacy provider. The new pharmacist had been booked to come and give training on medication and assess staff competency.

Staff recruitment practice was not safe. We found that two care assistants had started work before appropriate checks were completed. One had worked for three months before their criminal records check was returned; a second was working although their criminal records check was still in progress. The manager told us that they had seen recent criminal records checks from the staff members' former

employers, also in the social care sector. There was, however, no evidence of this on record, nor could we confirm that these staff members had always worked under the supervision of a colleague. This could put people at risk because the provider had not carried out appropriate checks to ensure that new staff were safe to work with people. Following our inspection, the registered manager wrote to confirm action had been taken to ensure that staff were supervised until all relevant checks were completed.

The lack of appropriate pre-employment checks was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were enough staff on duty and that they were available when they needed assistance. One person said, "The staff really do care, there are certainly enough of them to look after us and if I use my bell the staff respond quickly. I don't think there are any problems, there are enough staff at all times of the day". A relative told us, "To be honest I do believe there is enough staff here but I think you could always say more staff would be good to help". Only one person felt that staff did not come quickly enough when they used their bell to request assistance but even they said it was never excessively long. The home was staffed by a registered nurse at all times, supported by five care assistants in the morning, three in the afternoon and two at night. The manager, also a registered nurse, was usually available during the week to offer additional support when needed. Nursing and care staff were assisted by domestic and maintenance staff which enabled them to focus on providing care to people.

We discussed staffing with the manager. There was no system in place to calculate the staffing needs based on the dependency assessments in people's care plans. The manager explained that they were looking at this but for the time being, she was able to adapt the staffing levels based on her knowledge of people and their needs. Staff shared examples of when the staffing had been increased, such as to provide additional support and company to a person at the end of their life, to accompany people to appointments or to support outings. At the time of our inspection, the manager was using agency nurses to cover some shifts. Rotas for January 2017 showed between one and three day shifts covered by agency nursing staff. Staff told us they were happy with the staffing level and that they had time to spend with people. One care assistant said, "I've got time to sit with the residents which I really enjoy doing. It's the one to one time they need". Another told us, "We always have time to do the job well and to talk to the residents. Because of that, I know the residents very well, they are like family".

People were satisfied with the cleanliness of the home. One person told us, "Staff come in every day and clean the wash basin but I like to hoover my room. The communal areas are spotless". Another person said, "Staff come into my room every day and clean. My bed clothes are changed regularly too. My laundry is done for me and I always get the correct clothes back". One relative told us that the home was clean but not always as tidy as they would like. A cleaning schedule was in place and signed by staff to show when tasks were completed. The carpets were regularly steam cleaned and the provider planned to replace the flooring in communal areas. Personal Protective Equipment (PPE) such as gloves and aprons were available to staff and we observed them being used.

Although there were policies regarding infection control, the manager was not immediately aware of these. For example, we asked to see the policy on dealing with Norovirus and were initially told they did not have one. Later a policy was found, dated 2014. At the time of our inspection, there was no infection control lead for the home and no audits of the policies and practices in place were conducted. We did observe one bedpan on the rack in the sluice which was stained with faecal matter. Some staff also had long, painted fingernails which is not good practice for infection control, or for supporting people who may have fragile skin.

People told us they felt safe at the home. A relative said, "She's safe here, she's warm and she's looked after". In a survey conducted by the provider in Summer 2016, people reported they felt able to raise any concerns. One wrote, 'I feel I can approach any member of staff', another, 'Absolutely, I would tell the boss'. Staff understood their role in safeguarding. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. One care assistant described safeguarding as, "Making sure that the resident is safe, happy, well looked after and given the dignity and respect they deserve". Another told us, "If I saw anything untoward or the resident mentions something I would report to the manager and fill out forms". Staff told us they felt able to approach the manager if they had concerns. Information on how to raise a safeguarding alert with the local authority team safeguarding team was displayed on a noticeboard in the home and staff knew how to report any concerns.

Due to our concerns about people's safety, we shared our findings with the local authority safeguarding team and the West Sussex Fire and Rescue Service.

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 and found that people's rights may not have been protected. Staff had not received training in this legislation. They were unable to explain the purpose of the MCA and what it meant for the way they supported people. Although we observed staff involving people in day to day decisions, such as where they wished to spend their time and what they wished to eat, there were no systems in place to promote involvement in decisions if a person appeared to lack capacity. Although staff told us that some people were unable to understand and make some decisions regarding their care and treatment, there were no capacity assessments or best interest decisions on record. Some people had appointed lasting power of attorneys to act in their behalf in the event that they did not have the capacity to make decisions relating to their health or finances. There were some references in the care records regarding representatives but the manager did not have any copies of authorisations, which would be necessary to ensure that a representative was legally authorised to act on the person's behalf.

We noted some care practices which could be considered restrictive or covert. The person's ability to consent to their use should therefore be assessed. For example some people used bed rails to prevent them falling from bed. This could impede their free movement. Other people had their medicines administered crushed in food. This could be considered covert administration if the person was unaware that the medicine was present in the food. One of the people concerned was living with dementia. Staff told us that, although they told this person that they were taking their medicine, they could not be certain it was understood. It would be good practice to assess this person's capacity in relation to their medicines and to make a best interest decision involving their representatives and healthcare professionals in the event that they were found to lack capacity.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, eight applications had been made to deprive people of their liberty but none had been reviewed or authorised by the local authority. In discussion with the manager, we identified that she considered some other people were deprived of their liberty and that applications were needed. One of these people had moved to the home in September 2016. In their daily notes from January we read, 'She was upset and cross, complaining. Said she'd like to go home'. We found that applications were not always submitted in a timely way so as to ensure that restrictions on people's freedom to maintain their safety were the least restrictive possible.

People's capacity to give consent had not been assessed and the manager was unable to demonstrate they had acted 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 had received training but there were gaps in some areas. We asked the manager to update their training records, which we reviewed on the second day of our inspection. Training made mandatory by the provider included fire, infection control, moving and handling, dementia, safeguarding and first aid. This was delivered via a mix of in-house, visiting external trainers and staff attending courses run by the local authority. We noted that three staff had not attended training in safeguarding. The manager told us that they had identified these gaps through updating the training matrix. There were also gaps in first aid and dementia care training. Only two staff were recorded as having attended training in medicines management and no staff had been trained in the MCA. We asked the registered nurse about the training they had undertaken since taking up the post at the home. We found that, besides the mandatory training for care staff, no relevant updates such as on wound care, catheterisation, medication or taking blood had been provided. The absence of training in some areas had an impact on people's care. For example, staff were unable to describe how they maintained people's rights under the MCA and some staff were unclear on how to respond to emergency situations (you can read more about this in the 'Safe' section of this report). We found that the system in place to monitor staff training and development was not operating well and that staff may not have received appropriate training to enable them to carry out their duties effectively.

Despite this, staff told us they felt supported. One care assistant said, "If I need to know anything I just ask, no problems". Another told us, "It's really easy to go to them". We found, however, that staff had not received any formal supervision since July 2016. Records showed that staff had attended at least one supervision with the former registered manager during the past twelve months. None of the staff had attended a performance appraisal. A system of supervision and appraisal is important to monitor staff progress and support their professional development. The manager showed us a supervision and appraisal plan for the year ahead. This included five supervisions and one appraisal for each staff member. We noted that dates had been scheduled for appraisal meetings.

Staff had not always received appropriate training, supervision and appraisal to enable them to carry out their duties. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had plans to improve the staff training. Future courses had been booked to meet outstanding training needs. New staff were working towards the Care Certificate, a nationally recognised qualification. One care assistant told us, "I am starting my NVQ3 in February. My manager encouraged me to do this. I've done COSHH, fire training, and I'm going to be trained as a fire warden in February. Twelve of us are doing it. This is the first time I've had face to face training. I love it. There are lots of opportunities to learn here".

People enjoyed the meals at the home. Meals were brought in from an external provider and heated up on the premises. There was a choice of two hot options at lunch and a lighter supper option. People were asked in the morning what they would like for lunch and in the afternoon about their supper preference. If people wanted something different, kitchen staff were available to make alternative dishes such as omelettes or sandwiches. One relative told us, "I think the food is exceptional, I don't think you can better it. My wife can't eat the fish on Fridays so the staff make her an omelette". We observed that staff were available to support people with their meals, either in the dining room or in their bedrooms. Some people used aids such as lipped plates or beakers to enable them to eat and drink independently. If people wished to eat at different times, this was accommodated. We saw staff preparing one person's lunch at 2pm, as they had been sleeping earlier in the day. A relative told us, "She likes the food. She's well fed. Sometimes if she's hungry the night staff make her a sandwich".

Staff were knowledgeable about people's, likes and dislikes. Although the information available to staff in the kitchen was out of date, staff were able to tell us that one person had a nut allergy and that another required a soft diet to minimise their risk of choking. They were also able to tell us about specific requests, such as for kippers and a particular brand of crisps which they purchased specifically for one person. People appeared to enjoy their meals and were offered second helpings. We observed that drinks were available to people in their rooms and in the communal areas. Staff supported people to drink and ensured that hot drinks were refreshed.

People were happy with the support they received. One person said, "Everything seems fine, they all seem nice people and are very helpful". Another told us, "The staff are first bl**dy class!" A relative said, "The care has always been good, the staff seem very on the ball". People had access to healthcare professionals, such as the GP, chiropodist and audiologist. Staff supported people to attend external appointments. A nursing healthcare professional that we met told us, "They listen and follow advice".

The provider was making improvements to the premises. The garden had been enhanced, with new fencing and the addition of window boxes outside people's bedrooms and raised beds to enable people to participate in planting. There were plans to replace flooring in the communal areas, renew lighting to remove the strip lights and replace them with a more homely alternative and to purchase new furniture. The home was not purpose built and some people told us that storage was an issue. This had also been shared with the provider via their survey in Summer 2016. We read, 'Insufficient storage, wardrobes and drawers full of bed linen and packets'. The manager told us that they were looking into the possibility of slim-line wardrobes for the storage of personal care products, which would avoid the need to store these alongside people's clothing and personal effects.

At the time of our visit, there was little by way of adaptation to make the environment more suitable for people living with dementia. There was no signage to help people orientate themselves and to easily locate their bedroom or communal spaces such as the dining room. The manager explained that they were going to redo the bedroom doors and hoped to add memory boxes to the corridor wall. These would contain items relevant to the person such as photographs or objects, which may help them to identify their bedroom. New, brightly coloured trays had been ordered for the dining room and were in use by the second day of our visit. The colour contrast can help people to better identify the meal set before them. One care assistant told us, "They're great, they can actually see what they have on their tray".

Requires Improvement

# Is the service caring?

## Our findings

People were not fully involved in planning their care and support. Relatives told us that staff kept them updated with any significant changes but said there was no system whereby they were involved in reviewing what was working well and what changes, if any, needed to be made in the person's care. One relative told us, "I am aware of care plans and I believe I've seen one in my wife's room, but staff have never gone through one with me and my wife and so I'm not aware of it being updated".

Where people lacked capacity to make decisions, the systems in place were insufficient to ensure that choices would be made in the person's best interest and involve the people close to them (you can read more about this in the 'Effective' section of this report). In one person's care plan we read they had made a living will. There was, however, no record of this on file and the manager was unaware of its contents. Few people had made an advance plan detailing the care they would wish to receive at the end of their life. A review carried out by the manager in January 2017 found that just eight of the 20 people in residence had documented their wishes in this way. In one advance plan, we read that the person wished for the plan to be reviewed in the event that their partner passed away before them. The person's partner was deceased in September 2016 but the plan had not been reviewed with the person or their representatives. We recommend that staff take a more proactive approach to involving people in decisions relating to their current and future care. This would help to ensure that the care was appropriate, met their needs and reflected their preferences.

People felt involved in day to day decisions relation to their care. We saw that preference questionnaires had generally been completed with people on admission and reviewed by staff as part of the monthly care plan update. In one review we read, '(Name of person) is unable to respond but there is no objective indication that these preferences have altered substantially'. People told us their decisions were respected. One person said, "It is what I want to do, not what they want me to do". In response to the provider's survey in Summer 2016, one person wrote, 'Yes, they (staff) understand me. They always make time to listen'. In the minutes of a relatives' meeting we read, '(Name of relative) said that her husband prefers to have his soup in a cup and that the staff were approachable about this and remember to serve soup in a cup for him'. We read that one person had given up smoking and was using nicotine patches as a substitute. We spoke with this person who confirmed that this had been their decision. Throughout our visit, we observed that staff spoke with people and asked them what they would like, for example if they wished to return to their bedroom after lunch. One staff member told us, "We sit and talk to them, we ask them".

People were involved in decisions relating to the running of the home. Although there had not been any resident meetings since August 2016, people told us that they felt involved. One person told us, "I think the home is well suited for my needs, I love it here. We are encouraged to get involved. For example we were all consulted about the decorating of the home. The new owner is doing a good job trying to improve the home for us, so we all had a say in the colours that were chosen".

People spoke highly of the staff who supported them. There was a regular staff team at the home which helped to foster good relationships. One person told us, "Staff treat me well. I'm not the best patient but

they are still kind and caring. I can't expect more quite frankly, they are sensitive and caring in what they do". Another said, "You just saw how the staff were when they came into my room, they are wonderful. The manager is equally really, really good". They added, "I must endorse the word 'extremely' because that's what the staff are; extremely wonderful, kind and caring, simply that!" During our visit we observed that staff spent time with people and engaged with them in conversation. There was warmth between them and staff were able to share jokes with people. For example, after lunch when the pudding had been very much enjoyed, a staff member joked, "Because of your second pudding we've got to run round the block", to which people in the room laughed. Relatives were equally complimentary about the staff. One said, "I can't fault the staff here. (Nurse) is wonderful, she always comes in and chats". Another told us, "They talk to her quite a lot, they understand her. They sit with her so she isn't lonely. They're very patient".

People told us that staff treated them with respect and were mindful of their privacy. One person told us, "I can ask for help at any time and I'm not made to feel like a nuisance or that I'm interrupting them. They always put me at ease without me feeling embarrassed. The staff always knock on my door before they enter my room". In response to the provider's survey one person wrote, 'My privacy or company is always my choice'. Another commented, 'The staff are polite and courteous at all times'. Staff told us that they respected people's wishes. One care assistant said, "We always ask permission to do something like washing or changing them. We always knock on the door. We close the curtains if we're going to give personal care. If people decline this care we respect their wishes". Throughout our visit we observed staff treated people kindly and with respect. People were offered extra blankets if they were feeling chilly, invited to wash their hands before lunch and any food spilt on clothes was discreetly cleaned up. We observed that one person was offered assistance to change their top after lunch, but this was declined.

Requires Improvement

# Is the service responsive?

## Our findings

When a person moved to the home an assessment was completed. This detailed the person's medical history, key details regarding their care and specific details such as weight and height on admission. Nursing staff used this, along with a preferences questionnaire completed with the person or their family, to plan the person's care and support. Although each person had a care plan in place and the information was signed as reviewed most months, we found they were not sufficiently detailed or accurate to ensure that people received good and consistent care.

Care plans were often of a generic format, where staff simply entered the person's name in the gaps. On occasion we found that the plan referred to 'he' when talking about a female and vice-versa. We also found discrepancies in the person's date of birth and room number within the same care plan. Care plans were in place for areas of support including wound care, night care, pain, communication, behaviour and meals. We found, however, that they did not always reflect the support needed or care provided. For example, a care plan for one person, dated September 2016, stated they had a pressure injury to their sacrum. The care plan was signed and reviewed as recently as January 2017 with the instruction, 'Continues as above'. We found, however, that this person's injury had healed. Another person's care plan guided staff to reassure them as to the whereabouts of another resident. This had been reviewed in December 2016, although the person concerned had not lived at the home for at least two months. The information available to staff was not always accurate would could result in people receiving unsafe or inappropriate care.

There was little evidence of supervision by clinical staff to check that basic nursing care was being carried out consistently and that people's needs were met. In some people's care plans for 'Pain' it stated that staff should document the person's pain using a tool called the Abbey Pain Scale. This tool helps staff to assess the level of pain a person is experiencing when they may be unable to verbally communicate how they are feeling. There was no evidence in the records that this tool had been used, which could mean that people did not always receive pain relief when needed. Staff would also be unable to monitor the person's pain levels to respond to appropriately to any changes in their needs. We identified other areas of support that were not documented, for example mouth-care. The registered nurse on duty confirmed there was no system by which they could check care staff had assisted people with brushing their teeth or cleaning dentures. Monitoring charts, including for people's bowels, behaviour and fluid intake contained gaps (you can read more about this in the 'Safe' section of this report). Where body maps had been used to record injuries such as skin tears or bruises, there was no evidence of follow-up to ensure that the injuries had healed. One record referred to a bruised shoulder in November 2016 but there was no further information about this available in the records. The daily notes about people's experience were brief and task focused. They did not give a picture of how the person had spent their time or of the extent of the care provided.

The lack of accurate and complete records in respect of each person put people at risk of receiving in appropriate or inconsistent care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was aware that the care records were not fit for purpose. She told us, "People are safe and

they receive a good standard of care, our biggest downfall is documentation". She informed us that an electronic care records system had been purchased and was due to be installed on 1 February 2017. The manager hoped that in transferring the information from the paper to the electronic records, they would be able to update it, remove duplicated details and make it more personalised. Staff spoke positively about the planned change. One care assistant said, "The paperwork is not very good, as in we forget to write things. I think the tablets (hand-held computers) and the document holders in the rooms will help". During our inspection we observed that new document holders had been placed on the walls in people's bedrooms. These were intended as an interim measure to store monitoring records so that staff could complete them immediately care had been delivered. Another care assistant said, "You're going to be able to do it (make a record) there and then".

Although there were issues with the records, care staff knew people well. They appeared to understand their preferences and know how they liked to be supported. We observed staff responding quickly to people's needs and requests. For example, after lunch one person realised they had forgotten to bring their walking stick with them. A staff member quickly went to find this for them. Another person had been to an appointment and was accompanied by a staff member. A relative told us how staff had accompanied their mother to hospital and that being with 'a familiar face' had helped to calm and reassure her. In one card of thanks to the staff, we read, 'I know she was very happy there and that you gave her great comfort'. We noted examples where staff had responded to changes in people's needs, such as by calling the GP or arranging for a new, thicker mattress to be delivered.

Staff told us that the handovers were useful and helped them to keep up to date with changes in people's needs. One care assistant said, "We're good at transferring information at handover, it's more if it is recorded or not". There were, however, instances where staff had not responded in a timely way to incidents or changes in a person's health. These included a lack of action following a medicines error and the fact that a swab had not been sent to check the health of a wound which was noted as having an, 'Offensive smell'. This meant we could not be assured that people would receive responsive care at all times.

People were able to engage in limited activities. Activity staff worked in the home for one and a half days each week, and during the afternoons on alternate weekends. An activity planner for the year showed monthly activities as an outing, a communion service and weekly activities with the activities coordinator. Approximately every two months a visiting entertainer was booked. On the days we visited, there were no specific activities planned and many people appeared to be disengaged and sleeping during much of the day. Activity records that we sampled showed between two and five activities recorded in the month. These included nail care, reading, an external entertainer and one to one time. These records were maintained by the activity coordinator; care staff did not record activities they did with people or one to one time spent with them.

We observed that care staff took time to chat and engage with people. As many people were in their rooms, this was important to reduce the risk of social isolation. One care assistant told us, "People who are in bed all the time, I like to have a chat with them. You've got that time and it's lovely". Another said, "I actually feel like a carer", meaning that they had time to engage socially with people, rather than only being with them when providing personal care. Some staff brought their dogs to work, which seemed to be greatly appreciated by people. The activity coordinator told us that one to one activity was usually preferred. She said, "Everybody is individual. A lot is on a one to one basis. I have to go by how they are. It varies each time I come in". There was information about each person and how they liked to spend their time. Staff we spoke with were able to tell us about people and their interests, such as knitting, gardening or painting. They described how they used the garden and took people to the beach in warmer weather. In one card of thanks from a relative who had received a photograph of their Mother by the sea, we read, 'This is utterly amazing!

Thank you so much for your obvious encouragement to get Mum outside – and what a success!'

People felt confident to raise any concerns. One person told us, "Management have told me if I have any problems I can speak to them, the manager seems approachable and the staff team are always happy". Relatives also felt able to speak directly to staff. One told us, "If there is something I want to mention I go and talk. They do take notice of what I'm saying". Another said, "The radiator was cold this morning and (maintenance staff member) came to sort it immediately. That's efficiency". In the provider's survey from Summer 2016, comments included, 'Only once we needed to say anything and it worked' and 'No concerns of fears of repercussions'. The manager had not held any resident and relative meetings; the last one was under the former registered manager in August 2016. Some people and relatives told us that they preferred to discuss things on a one to one basis and didn't attend the meetings. Others felt they would be useful. The manager and provider told us that they intended to hold a meeting once they had all the dates for planned improvement work, so that they could update everyone.

People told us they knew how to make a complaint, however the complaints policy available was out of date. Whilst it explained how to make a complaint and the anticipated timescales for response, the details of who to contact were not current. They referred to the former registered manager and owners of the home. There was information about organisations to contact if the complainant remained dissatisfied but no contact information was provided. A log of complaints and compliments received had not been maintained but we reviewed the one complaint received by the manager since she started in post. This had been responded to the following day. Following our inspection, we received an updated complaints policy from the provider. Staff confirmed that this had been displayed. This meant that people would have clear information on who to contact if they wish to raise any concerns.

Requires Improvement

# Is the service well-led?

## Our findings

There was no system in place to monitor the quality of the service and to ensure compliance with the regulations. During this inspection, we identified five breaches of regulation and found people were not always protected from risks to their health, safety and welfare.

The manager did not have a system to monitor how the service was delivered and ensure that it was safe for people. Policies and procedures were out of date. They had not been updated since the new provider took over the service in March 2016. There were no audits to check that medicines were administered safely, that the premises and equipment were safely maintained, that staff had received necessary training or that care plans enabled staff to meet and respond to people's needs. There was no oversight to ensure people had received the care they needed and that their health and social needs were met. This meant that problems in these areas persisted and there was no clear plan to address them.

The provider had commissioned an audit by an external company in December 2016. The report recorded areas of concern, many of which we identified and have detailed in this report. We asked the manager how they had used the report to plan and make improvements to the service. Although the manager was able to highlight specific actions, such as the purchase of a new bin in the sluice area and the agreement for administrative support, there was no clear plan of action to describe how and by when the other issues would be addressed.

The lack of a system to assess, monitor and improve the quality and safety of the service and to monitor and mitigate risks to people was breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where accidents or incidents occurred, these were logged and reviewed. This helped to identify any patterns or trends and to reduce the risk of future injury. We noted that action had been taken to reduce the risk of reoccurrence, for example referrals had been made to the GP for a medicines review or to the falls prevention team. The provider had also agreed to install a new call bell system, which would provide an emergency bell facility for staff to call for assistance. It would also allow for sensor mats and sensory beams (used to alert staff when a person is up so that they can attend and hopefully reduce the risk of the person falling) to link to the system. There were records of checks by external professionals on moving and handling equipment, such as hoists and slings to check they were safe for use.

The provider had asked people and their relatives for feedback on the service during July 2016. The responses were positive and the manager told us there were no actions for follow-up. The provider told us they hoped to repeat the survey each year. The feedback we received about the service was positive. A relative told us, "Things have improved". A care assistant said, "There have been a lot of changes but it's good. The new owner wants to put into the home which is nice. He is interested in what is going on". Improvements that had been completed included new garden fencing, clearing three skips of 'clutter', the purchase of a new back-up boiler and a new dishwasher. Staff felt involved in the development of the service. The manager held regular staff meetings which served to provide updates and reminders, as well as

to listen to their feedback.

A new manager was in post and was in the process of registering with the Commission. This person formerly worked at the home as the clinical lead and had returned in January 2016. They were appointed as manager in October 2016. As the manager was a registered nurse, the post of clinical lead was not due to be filled. By way of support, one nurse worked two days on assessments and paperwork and a new arrangement was in place for two care staff to provide thirty hours of administrative work. The provider and manager were aware they needed to make improvements. They had lots of ideas on the changes they wished to make. Some of these plans, mostly relating to purchasing new systems and improving the premises, were clearly detailed with planned completion dates. There was, however, no overarching plan or timeline for how improvements in the quality of care would be achieved.

The manager was well regarded by people, their relatives and staff. One person told us, "The manager is fantastic, she's approachable and knows how to look after her staff team. They are always happy and do a good job". A relative said, "(Name of manager) is a very efficient person". The manager was conscious of how much work there was to do in order to improve the service. She told us, "I'm still finding my feet. Lots of things are getting sorted out but there is lots to do". The manager was enrolled to complete a diploma in Health and Social Care at Level 5, a management level qualification. The manager worked closely with the provider. She told us, "He (the provider) is very supportive. He rings virtually daily". She also explained that she was looking into local manager forums and support groups as a way of sharing experience and updating herself on good practice.

The culture of the home was open and friendly. People and staff spoke positively about living and working there. One person said, "The Staff are kind and caring and they treat me well. My visitors are able to come and see me whenever they like, they are made to feel welcome with a nice cup of tea". A care assistant said, "It's lovely. It's friendly and bright and a lot more relaxed than I'm used to which does the residents the world of good". Another told us, "It's a relaxed atmosphere, without being laid back". An agency nurse who was working in the home for the first time told us they had been welcomed and supported.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent |
| Treatment of disease, disorder or injury | Consent of the relevant person had not always been established before care and treatment was provided.<br>The manager had not acted in accordance with the 2005 Act.<br>Regulation 11 (1) (3) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | Care and treatment was not provided in a safe way because risks had not been consistently assessed and action had not been taken to mitigate them.<br>Medicines were not managed safely.<br>Regulation 12 (1) (2) (a)(b)(g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | Systems had not been established to ensure compliance with the regulations, to assess, monitor and improve the service and to monitor and mitigate risks to people's health, safety and welfare.<br>Records in respect of each service users were not accurate or complete.<br>Regulation 17 (1) (2) (a) (b) (c) |

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Recruitment procedures were not operated effectively.<br>Regulation (2) (a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not received appropriate training, supervision and appraisal as is necessary to enable them to carry out their duties.<br>Regulation 18 (2) (a) |