Whisselwell Care Limited

The Priory Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

An unannounced inspection took place on 3 and 11 May 2016. The inspection had been brought forward as concerns had been raised about a number of issues. These included staffing levels and care and treatment of people living at The Priory.

The home was previously inspected in July 2015. At this comprehensive, unannounced inspection, the home was rated as requiring improvement.

The Priory Residential Care Home provides accommodation and 24 hour care for up to 21 older people, some of whom have dementia and some who have physical frailties. There were 20 people living at the home on the first day of inspection and 19 people on the second day of inspection.

The home is located in Ottery St Mary, a small town in East Devon. The Priory had been adapted from a large three storey house set around a small courtyard with bedrooms on all three floors. Communal areas include two sitting rooms and a dining room. A day service for six people is also provided in the home by three staff who use one of the lounges and the dining room for activities. These staff also support people who live at The Priory if they wish to join in the activities.

The home has a registered manager, who is also the provider. 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.

The registered manager was supported by two assistant managers who oversaw the work of three shift leader care workers. Shift leader care workers were responsible for managing the work of the care workers who were on duty.

The registered manager had not ensured that there were sufficient staff at all times. They said they had not used a dependency tool to identify how many staff were required, but were able to assess this based upon their knowledge of people's needs. However, we found there were times when there were not enough staff to meet people's needs. Staff had raised concerns about the lack of staff but the registered manager had not taken action to address these concerns. This meant that at times, people were distressed and unhappy with staff not being present to respond. One person was at risk of developing pressure sores because staff did not ensure they were supported to go to the toilet sufficiently often. Health professionals expressed concern about the care provided, which, they said, had led them to visiting the home more often than they would have expected to.

Staff had not always been recruited safely as we found the provider had not always completed checks on the new member of staff before they started work. Staff had not completed all the training and supervision required to ensure they had the skills and knowledge to carry out their role effectively. Senior staff said that

due to the staffing pressures they were aware that they had fallen behind with the supervisions they had planned to complete.

Although senior staff were aware of the types of abuse that people should be protected from, they had not taken appropriate action, such as reporting allegations to the local authority.

The home was generally well maintained, clean and odour-free, although there were some areas, such as the laundry which posed an infection risk. Following the inspection, we received information from the provider that the laundry was being redecorated and repainted. We also identified that the home had not been adapted to suit the needs of people with dementia.

People had been risk assessed when they were first admitted to the home and care plans developed which provided detailed information about the person and their needs. Care plans also had information about the person's history and family. However, some care plans had not been updated as people's needs had changed. For example one person's mobility was not described accurately in their care plan. This would mean that new staff may not be aware of the person's needs.

The registered manager and staff understood their responsibilities under the Mental Capacity Act (2005). Applications had been made for Deprivation of Liberty Safeguards (DoLS) authorisations where needed.

Although there was some governance and quality assurance processes in place, these had not always identified issues. For example, care record checks had not identified or addressed issues such as charts recording weight and food/drink not being completed fully. The registered manager relied upon senior staff to do some of the quality assurance checks. However there was no evidence that, when these had not been completed, actions to address the shortfalls had occurred. Following the inspection, we received information from the provider that audits systems had been modified to address these concerns.

People were supported to receive their medicines safely and access health and social care professionals such as their GP, dentist and district nurses. Specialist advisors such as speech and language therapists and mental health teams had also been consulted when necessary.

Staff were generally very caring and supported people with compassion. Staff clearly knew people and their families well. People, relatives and visiting professionals said they thought staff were very good. However there had been some instances where people were not treated with dignity and respect. For example they were referred to by staff, using inappropriate language. The home had a complaints policy and people and their relatives were aware of how to make a complaint. There was evidence that when complaints were received, these were dealt with appropriately.

People were generally positive about the meals at The Priory. However, fluid and food charts for people who had been assessed at risk of not eating or drinking enough were not always fully completed. This could place people at risk of not receiving enough food or hydration to maintain good health.

Group activities, both in and out of the home were offered to people. These included music sessions, quizzes, games, visits to the seaside and theatre, arts and craft. However, people who did not want to take part in group activities were not well supported to do individual activities of their choice.

We found 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 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.

There were insufficient staff to support people safely. Checks to ensure new staff were safe to work with vulnerable people had not always been completed before they started work.

The provider had not always taken steps to ensure people were protected from abuse.

People received their medicines from staff who knew how to administer medicines, record and store them safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always been supported through regular supervisions and appraisal. A senior staff member said this was due to staffing pressures.

Staff did not always receive the right training and support to ensure they were effective and competent in their role.

There were not effective systems in place to ensure people were receiving adequate food and fluids.

The provider had ensured they operated within the requirements of the Mental Capacity Act 2005. People's capacity to make specific decisions had not always followed best practice guidance.

Where necessary applications had been made for Deprivation of Liberty Safeguard authorisations.

People were supported to see health and social care professionals when necessary.

Is the service caring?

Requires Improvement

The service was mostly caring.

Staff generally showed care and compassion when working with people. However there were a few occasions when staff did not talk about people in a respectful way.

Staff knew people and their families well and had positive relationships with them

Staff took into consideration people's preferences when supporting them.

Is the service responsive?

Requires Improvement

The service was not fully responsive to people's needs.

People's needs were not always met in a timely way.
Care plans were not always up-to-date and did not reflect the current needs of the person when these had changed over time.

There were systems in place to listen to and respond to concerns and complaints.

Staff did not always complete all care records, such as charts to record when people were turned in bed. This meant that staff could not be confident they were always addressing people's needs.

There were activities arranged both inside and outside the home which people joined in. People were able to contribute ideas at regular resident meetings. However, it was not clear what impact this had on making changes or improvements to the service provided.

Is the service well-led?

Requires Improvement

The service was not well led.

Quality assurance systems had not always been completed. When improvement was identified as necessary, action was not consistently taken to improve the quality of the service.

Allegations of abuse had not been reported to the Care Quality Commission as required.

Staff were able to contribute ideas to improvements through staff meetings as well as at hand-over sessions and supervisions.

The Priory Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 11 May 2016 and was unannounced. It was carried out by a lead inspector who was accompanied on the first day by another two inspectors. On the second day of inspection the lead inspector was accompanied by one inspector. The inspection had been brought forward as concerns had been raised about a number of issues. These included staffing levels and the care and treatment of people living at The Priory.

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

The service completed a Provider Information Return (PIR) about how they ran the service in May 2016. This was reviewed after the inspection. The PIR is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make.

During the inspection, we met most of the people living at The Priory and talked with 13 of them at various times during the inspection. We met and talked to the provider, an assistant manager, five care staff, the cook and the cleaner. We looked at four people's care records and three medicine records. We also looked at four staff records. The records included training, supervision and appraisal records. We looked at quality monitoring information such as health and safety checks, cleaning schedules and audits.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experience of people who could not talk with us.

During the inspection we met and talked with eight relatives. We also met one local health and social care professional. After the inspection we were contacted by a visitor to the home.

Inadequate

Is the service safe?

Our findings

People were at risk of harm or unsafe care because there were insufficient staff to meet their assessed needs. The provider did not have systems in place to determine safe staffing levels and ensure each person's individual needs were met at all times.

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Before the inspection, we received an anonymous concern about the number of staff on duty at The Priory. During our inspection we found the concern we received had been correct and people were not receiving adequate support from staff to meet their needs or keep them safe. For example, when we arrived at 9am on the first day, we found only two care staff were on duty. We asked a senior member of staff how many staff there should be on duty at that time of day. They said there was supposed to be an assistant manager, one senior care worker and three junior members of care staff on duty to support people. The two staff were supporting some people with their morning routine of washing and dressing as well as other people who required care in bed. A number of people were already up and dressed and were in the lounges and dining room. This meant staff were unable to support the needs of these people as well as support people to get up at the same time. Staff said there were often periods in the day where there was a shortage of staff, which meant they were unable to support everyone safely.

Throughout the first day of inspection people were not able to have their needs met promptly by staff. For example, during the lunch hour there were, at times, no staff in the dining room, where one person was very agitated which was upsetting other people in the room. The person was singing loudly or calling out. We heard one person say "Could we have some silence please" and another putting their hands over their ears. Care staff were not always present to support the agitated person or reassure the rest of the people in the dining room.

Three people were in a lounge after lunch. One person kept shouting at another. They said "Oh you shut up" and "Go where you want to go. I hate you". The other person looked upset and said "I hate you too" and then left the room. They came back a few minutes later. No staff were in the lounge whilst this was happening. We had identified similar concerns during the December 2014 inspection and had alerted the registered manager to these concerns. At that time, they had said they would advise staff to be more vigilant. However staff said they were not always able to be in the communal areas as they needed to prioritise support for people in their bedrooms.

We discussed the cooking arrangements with the registered manager as we had concerns that care staff had to serve and clear the evening meals as well as cook at weekends. Care staff had to ensure they prepared the specialist meals required and support people who needed help with feeding. The registered manager agreed to consider employing additional cooking staff to reduce the burden on care staff. Following the inspection, the registered manager said they had appointed additional kitchen staff so that meals at

weekends and evenings would not be done by care staff.

One person's records showed they had fallen off their chair on three occasions in recent months. When we observed this person for a period of an hour, we saw they repeatedly tried to get up out of their chair. This went unnoticed as either there were no staff present or they were busy attending to other people who were being more vocal and therefore receiving staff attention. The same person had previously had a pressure sore, however we observed that they were not moved or taken to the toilet for four hours. Not taking this person to the toilet put them at increased risk of pressure damage because they had continence issues.

Prior to the inspection, a health professional said they had significant concerns about the care provided to people and that the community nursing team were therefore visiting daily. They also said that they were undertaking additional checks three times a week due to the concerns they had. They had noted that some people had deteriorated and become highly dependent which had led to them needing hourly interventions by care staff. They said that the staff at The Priory were not managing this. They said they were unsure whether this was due to poor organisation in terms of allocating specific staff to support particular people or due to insufficient staffing. They described the impact on people as being the potential to cause skin lesions due to soiled pads as well as causing high anxiety for people and their families.

A district nurse reported during the first day of our inspection that one person who was reluctant to get up had developed a grade two pressure sore. A senior care worker said this person only got up when their family visited, which was usually every other day. Staff said they tried to encourage this person to get up, but there was not always sufficient staff on duty to continue to attempt to get them up as this was time consuming and staff were needed to support people already up and moving about.

Staff said they felt under enormous pressure as they did not have enough time to support people safely. A visitor described how the person they visited had been told there were not staff available to support them to the toilet at times and therefore they had been distressed.

The registered manager said there were two people who were cared for in bed. They described how there were four people who had pressure sores who needed to be moved regularly to ensure the pressure sores could heal. They said there were also four or five people who needed help to go to the toilet every hour. This was confirmed as four people after the inspection. They described how, because of the complexity of people's needs, they had had to increase the staffing levels during the day. However there was no evidence that this had occurred.

We asked the registered manager and senior staff whether they used a dependency tool to determine the staffing levels that should be provided in the service. They said they did not as they were able to decide staffing levels without a tool. After the inspection, we were informed that a dependency tool was being used to help calculate staffing requirements. They said that there should be a senior care worker and three care workers in the morning. They also said there should be a senior care worker and two care workers in the afternoon. Rota sheets showed, on particular days in the four weeks prior to the first day of inspection, there were not these numbers of staff on duty. For example, on Sunday 24 April 2016, there had been one senior and one care worker on in the morning and one senior and one care worker on in the afternoon. The rota also identified that a shift from 7am to 7pm needed to be covered but did not identify whether it had been. A senior worker said there had been a week at the end of March 2016 when they had needed to find staff to cover 42 hours but had only managed to get staff to work 21 of these hours.

The senior care worker added there should be two care workers at night, who worked from 7.00pm to 7.00am. Both night staff were expected to be awake at night and undertake some cleaning and laundry

duties as well as care for people, including administering their medicines. They said this had always happened even during staff shortages. Rotas showed there were two staff on night duty during the last four weeks. However, on the 20 April 2016, one of the waking night staff was shown as an assistant manager who was also shown on the rota as working from 8am to 4pm that day and then working 8am until 10.30am the following day. This meant that the assistant manager had worked 26.5 continuous hours with only four hours break.

After the inspection, we asked for further information about the needs of people during the evening. We received detailed information about what needs people had in terms of supporting them to go to bed. This included their preferred time for retiring, whether they needed the support of one or two carers and how long this support usually was needed for. Using this information, it was clear that two staff could not provide all the support needed. We discussed this with the registered manager who said they were reviewing how many staff were needed in the evening to support people safely.

The senior care worker described how a cook worked in the morning until 2.00pm, but care staff were expected to serve and clear up the evening meal. At weekends, care staff were also expected to cook and serve all the meals. A cleaner worked six days a week but, when they were not at work, staff were expected to undertake cleaning, when necessary. This meant care staff were not always able support people safely.as they had to spend time doing other tasks. After the inspection, we were informed that additional staff had been employed for kitchen duties. This meant that there were kitchen staff on duty for all meal times throughout the week.

We asked a senior member of staff how staff deployment was managed to ensure staff supported people safely. They said they prioritised people who needed to be moved regularly to prevent pressure areas and also prioritised people who needed support to go to the toilet. However, they added that staff had to support people on all three floors of the home. They said this meant there were not always enough care staff to deal with people's care needs and provide enough one to one support. They described how some people sometimes rang their call bells frequently, and staff needed to keep going to their room, which meant they were unable to attend other people promptly. They said this meant staff were even more pressured. This happened on a number of occasions on the second day of our inspection.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
We discussed the staffing levels on the first day with the registered manager as we had immediate concerns about the level of staffing in the afternoon. The registered manager said there had been problems due to the number of staff who had left the service. They said they were in the process of recruiting new staff which meant in the near future staffing levels would be adequate.

However, they acknowledged there was a problem with the current staffing levels and agreed to engage some agency staff until the new permanent staff were in post. At the second day of inspection, senior staff said they had used agency staff to supplement staffing levels on some shifts and some new staff had commenced working. The registered manager also said that the activity workers were working over the weekend, to be able to help provide some support to people living at the home. This was a temporary arrangement until new care staff had started at the home. This was an improvement on the previous staffing levels. However the registered manager had not undertaken a review of dependency levels so it was not possible to establish whether there were sufficient staff at all times.

Following the inspection we received a further concern about staffing levels at the weekend. We discussed this with an assistant manager who said there had been sufficient staff on duty on the weekend in question,

although there had been some changes to the rota due to sickness.

Staff were not always recruited safely. Recruitment checks for two staff had not been carried out. Both staff had worked at the service previously and the registered manager said they had not thought they needed to carry out new checks, such as new applications forms and the Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

Another member of staff had started working at the home in 2015. Their DBS check had been received after they started work and had not been risk assessed until 10 days after they had started. Although they had two references in their file, one of these was received after they joined and the other was a personal reference rather than a work related reference. This member of staff had no record of any supervision in their file since they had joined the home. Issues relating to staff recruitment procedures had also been identified in the inspection in 2014. This meant vulnerable people could be at risk of being supported by staff who had not had the proper checks in place.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Since the inspection, the provider has amended their recruitment procedures to ensure that checks are made on staff being re-employed, to ensure they are still suitable.

People were not protected from the risk of abuse, including bullying and harassment. There had been instances where people had reported potential abuse to senior staff. Some people raised concerns about a member of staff saying they were sometimes rough and could be rude to them. They also commented that the staff member had been disrespectful when handling their personal possessions.

We discussed the concerns with the registered manager and senior staff who said they were aware of some issues about the member of staff. They described some of the actions they had taken to address the issues with staff. However, there was no written evidence, for example in supervision notes or disciplinary letters, to show appropriate actions had been taken to investigate the occurrences and reduce the risk of recurrence. These allegations had also not been reported, as required, to the local authority or to the Care Quality Commission. This meant that the appropriate steps to involve the local authority safeguarding team and other agencies had not been taken.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Staff were able to describe what abuse meant and describe what their responsibilities were if they identified possible abuse.
People were largely protected from the risks of infection by staff who used personal protective equipment including disposable gloves and aprons when supporting people with personal care. However, the laundry floor was made of concrete and not permeable therefore posing an infection control risk. There were also areas of the ceiling where paint was flaky in the laundry and had not been repaired.

Some chairs in the lounges were worn and appeared to have engrained dirt on the arms. The registered manager said all chairs had been recovered in the last two years, but they would address these issues.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Following the inspection, we received information from the provider that the laundry was being redecorated

and repainted.

There were sufficient gloves at the home for staff to use and they were available in each room. The home was generally clean, tidy and odour-free throughout. The cleaner worked six days a week and had a routine for each day to ensure that all areas were covered regularly. The cleaner set high standards and said they really enjoyed working at the home. All of the cleaning equipment was locked away safely when not in use.

A fire door in the laundry area did not have a handle on it and consequently there was a hole where the handle should be. This compromised the effectiveness of the door to act as a fire break. The maintenance person rectified this during the inspection.

After the inspection we received a concern from a person who had been in an upstairs bedroom. They had been present when the fire alarm had rung for approximately 40 minutes. During that time, no staff had provided reassurance about what was happening to the person. They had finally checked with a member of staff who said the alarm was being rung for test purposes.

After the inspection, the registered manager checked the fire alarm records and could find no occasion in recent months when the fire alarm had rung for an extended period. They said that if this had happened they would have been contacted as well as the fire alarm company.

Following the inspection, we contacted a fire safety officer to discuss these concerns. The fire safety officer said the home had been inspected in August 2015 and had received a letter of non-compliance. They said they would visit the home to look at any issues which required addressing.

After the inspection the provider sent further information showing they had taken appropriate action. This included a copy of a report by a fire safety company which had taken place after the fire safety officer visit. The report showed that actions had been taken to address the issues identified.

People received their medicine safely. Prior to the inspection concerns had been raised regarding medicines administration. However, we did not find evidence to support these allegations. We accompanied a senior care worker on a medicines round. They followed correct procedures throughout, ensuring that they kept the medicine trolley safe and locked when they were administering medicines. Each medicine record had a photograph of the person and identified any allergies the person was known to have. Hand written entries on (Medication Administration Records) MARs were double signed and clearly written. There were no gaps on the sheets and they corresponded with information held on peoples care records. Medicines that require additional controls because of their potential for abuse were stored safely. Stock checks were completed and there were no discrepancies between the drug register and actual drugs in stock.

Requires Improvement

Is the service effective?

Our findings

People's needs in terms of nutrition and hydration were not always met. For example, we reviewed the fluid and food charts for one person who had been assessed at risk of not eating or drinking enough. Although staff had recorded what food and drink had been consumed, the amounts had not been totalled at the end of each day. There was no guidance to staff about the amounts people should be encouraged to eat or drink. This meant it was unclear if people were receiving adequate nutrition or hydration.

During a handover meeting between the morning and afternoon shift on the first day of inspection, a discussion took place about one person who was not drinking much. However, although staff described the person as "not drinking all fluids", there was no discussion about what should be done about this. Another person who was constipated was also discussed. A member of staff said that the person had been given prunes to help with the issue. However, there was no discussion about how long staff should wait before considering other options if this did not address the problem.

Although drinks were provided at meals and in the morning and afternoon, drinks were not readily available or accessible. During the morning of the first inspection day, one person asked if they could have a cup of tea and were told they could wait as lunch would be being served within the next ten minutes and a cup of tea would be served shortly after this. This was not responsive to the person's needs. On another occasion, a person asked for a drink and was given a cup of tea. This showed staff did not have a consistent approach to providing drinks to people.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Although people were encouraged to eat a well-balanced diet, not everyone living in the Priory said they were given a choice of what to eat. A main meal was served to people each lunch time and then a lighter meal was served in the late afternoon. The cook worked five days a week and the care workers did the cooking at the weekends. The cook decided on the menu on a week by week basis. There was very little evidence that people were consulted about the menus. In a resident meeting in December 2015, the minutes stated that meals were discussed, although the minutes only recorded one person's view. A sentence referred to whether it would be nice to have some themed meals in the new year. However there was no information about whether this was agreed and actioned.

The cook wrote the dish to be served at lunchtime main course in a diary, but did not write what any alternatives were. The menu was not displayed in the home; however the cook did go around in the morning and ask people what they wanted for lunch. Where people did not want the main meal, they were offered an alternative.

The cook knew which people were on specialist diets, for example people who needed a soft diet to reduce the risk of choking. The breakfasts and suppers were also prepared by the cook. The supper was then served by care staff in the late afternoon. Most people said they enjoyed the food at the home, for example one

person said "The food is much better than expected – it's excellent." However, one person on a soft diet commented that they got pureed mince and potato nearly every day.

Staff were not fully trained and supported to undertake their role effectively. Although staff had completed some training, records showed that not all staff had completed the training identified as mandatory by the provider. For example nine out of 25 staff had not completed safeguarding vulnerable adult training and six staff had not completed infection control training. This meant that people may be supported by staff who did not have the necessary skills and knowledge to do this effectively.

Training records also showed that only 10 out of 24 staff had completed training on the Mental Capacity Act 2005 (MCA). However, one care worker explained in detail what the MCA meant. They had a good understanding of it and recognised that some people have fluctuating capacity to make decisions. They were able to describe what staff needed to do to work within the legal framework.

Some staff had also undertaken specific training relevant to the needs of the people they supported. For example, staff had completed a tissue viability course and a nutrition and hydration course. However only six staff had completed training in dementia awareness although there were a number of people living at the home with dementia. This meant that staff might not understand those people's particular needs and requirements.

Senior managers said staff were usually supported in their practice through regular one to one supervision every three months. However they described how, because of staff shortages, this had not happened. Staff records showed that staff had received some supervision although not every three months. For example one record showed the member of staff had had supervision in June 2015 and then in January and March 2016. There were no records of supervision for a new member of staff who had started working in November 2015, although there was evidence that the person had undertaken an induction when they first started work.

Although we identified some concerns that staff had not completed training, one member of staff told us they had sufficient training at the home. This included completing a qualification and training in first aid, fire safety and health and safety.

Before staff started working at The Priory, they undertook an induction, which included familiarisation of the home and an introduction to people and their care plans. Records confirmed that these had taken place. One newer member of staff explained how they had had a full induction. They said they were shown the policies and procedures. Their manual handling skills had been checked when they first starting work. They said they felt the staff and the registered manager were really helpful. New staff also worked alongside more experienced staff to get to know each person and how to support them. We observed a new member of staff who carried out duties alongside staff who had worked at the home. New staff were assessed during their induction to see whether they had the right skills and attitudes to ensure good standards of practice.
Senior staff said new, inexperienced staff at The Priory were expected to complete the Care Certificate induction within the first three months of their employment. The Care Certificate is a set of national standards that social care and health workers should demonstrate in their daily working life. The standards should be covered as part of induction training for new care workers. Senior staff said new staff also completed training courses in subjects including safeguarding vulnerable adults, fire safety and food hygiene.
The provider had supported assistant managers to complete management qualifications as well as qualifications in care. Most other staff had completed, or were in the process of completing, qualifications in care.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people have been assessed as lacking capacity to make a particular decision, a best interest meeting should be held. This meeting should involve, wherever possible, health professionals and family or others who know the person well.

Staff had assessed people's capacity to make some decisions. However this had not always followed best practice. For example one person had a pressure mat placed by their bed because they were at risk of trying to get out of bed at night and falling. Their care records were contradictory. For example one document stated 'I can make decisions on all my daily life', although another document said they couldn't make daily decisions. The person had appointed a Lasting Power of Attorney (LPA), although there was no evidence that they had been contacted. There was no evidence of best interest decision making regarding the use of the pressure mat.
People were supported to make day to day choices, for example what time they got up and went to bed and what they wore. People were also given choices about joining activities that were going on in the home. For example we saw staff encouraging people to join in a quiz session, but respecting their right to refuse. However, we also found that staff did not always ask people about some decisions. For example in one lounge there was a large TV which was on all day. We asked the three people in the room, whether they had chosen the programme that was on the TV. They all said "No" and two people said they did not like the programme.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had made four DoLS applications to the local authority DoLS team for people living at the home, as they were under the supervision of staff at all times. Documents in the care records showed this authorisation had been submitted and people were waiting to be assessed by the local authority.

People had been assessed when they first came to the home to determine their care and support needs. Detailed risk assessments were in place for each person with clear actions described to reduce risks as much as possible. For example there were assessments of people's skin viability as well as their risk of falling and choking. Staff had worked with people and their families to develop care plans. The plans provided detailed information about what support the person required and how they liked the support to be delivered. The care plan also described personal details about the person, for example a life history and people who were important to them. There were some assessments which had been updated when a change occurred as well as on a regular monthly basis.

People were supported by a team of staff who knew people well and understood how to keep them safe whilst supporting them to be as independent as possible. People's physical, mental and social needs were assessed and care provided in line with their needs. For example, one person had been assessed as requiring two staff and specialist equipment, to move safely. During the inspection we observed two staff supporting this person to move using the equipment needed. Staff took their time and ensured that the

person was communicated with whilst supporting them. We also observed another person, who had been assessed as experiencing depression, being encouraged by staff to do things that might help to alleviate their depression. People who had been assessed as requiring a specialist diet, for example a soft food diet to reduce the risk of choking, were served meals that met their needs.

People were supported to see health professionals including their local GP, dentist, psychiatrist and members of the local mental health team. Where people's health needs changed, staff contacted relevant health professionals to arrange appointments. For example, staff had supported people to see their GP and the district nurses when an issue arose.

Staff described how they had supported one person with bereavement counselling to help them with their grief. They said they had also worked with the local mental health team to help with some of the person's issues. They described how they encouraged the person to get involved in activities including the recent theatre trip, which they had enjoyed.

A district nurse said the care staff were looking after one particular person very well. They did think however, that they were struggling to meet another person's needs, which they had fed back to the registered manager. They said that staff called the district nurses when needed and usually a member of staff accompanied the nurse with the people they were coming to visit.

However a relative said that they were concerned that staff did not always provide an accurate picture of their family member to the local mental health team. They said staff will say that the person was "fine" whereas the person was actually depressed and unhappy. Another relative described how when their relative had seen a health professional in an emergency, staff had not informed the relative about it at the time. They also said that when they had raised it with staff the following day, staff had been unaware of what had happened. They added that staff had apologised about this afterwards.

The home was well maintained in most areas. However, in one lounge, the television was in a corner of the room so most people would be unable to watch it easily. A visitor said the location of the call bells in each lounge was inaccessible for people who were less mobile.

Most of the interaction we observed supported the fact staff were promoting a homely environment, but some improvements could have been made to ensure this ethos was fully promoted. The environment was not as homely as it could have been. In both lounges, all the armchairs were placed against the walls which meant that people could not easily interact with each other. The registered manager said the arrangement of furniture was because a number of people used mobility aids and having a clear floor space was important. The registered manager also said they were looking at ways to make the home more 'dementia-friendly' which would include the environment.

People said they were able to personalise their bedrooms with furniture and decorations of their choice. Bedrooms we visited showed this to be the case. However, there was no evidence that people had been involved in choosing the décor and furnishings for other parts of the home. A member of staff said people had expressed dissatisfaction with new lounge chairs and the provider had replaced them with the previous chairs which had been reupholstered. Some bedrooms were on the third floor of the building. People in those rooms said the rooms got very hot in summer and were cold in winter. When we visited people in three of the rooms on the first day of inspection, the rooms were very hot despite windows being open.

A small courtyard provided the only outdoor space available to people to sit in. Although there was a bench in the courtyard, the area was surrounding by high walls on all sides and did not provide an adequate,

usable outdoor space for most people in the home. The registered manager said they were considering how they could adapt a small area at the back of the building to provide an outside space. After the inspection, the registered manager said they had now established a fenced garden area on the patio area in the car park, which was popular with people living in the home. A member of staff said that some people were able to go out with family and that once a month a trip out was arranged which some people chose to go on.

Requires Improvement

Is the service caring?

Our findings

Most people said staff were really kind and caring. Comments included "staff are kind". One person described a particular member of staff as "she's really good". A visitor said that staff were "always kind and polite" to the visitor and to the people in the home.

However, during the inspection we heard some language that was not respectful about people. For example a member of staff said "Do you want to start getting the walkers in?", when referring to those who were able to walk to the dining room. Other comments made by staff included "I'm going to let x feed you now" and "X has been fed" in front of other people in the dining room. We also observed some people being left with food protector bibs around their neck over two hours after their lunch, which did not promote people's dignity. We discussed this with the registered manager, who said they would address these issues with the staff concerned.

Most staff recognised the importance of treating people with dignity and respect. Staff were discreet when checking whether a person wanted to go to the toilet, phrasing the question to minimise any embarrassment. One person was hard of hearing and the care staff wrote down the question 'Would you like to use the toilet?' for them. Another person was worried as they could not find their watch. The care worker reassured them and went to look for it straight away for them.

One relative described the care given by staff saying "It's been going really well. Staff are very friendly, very helpful and very kind. No problems at all." We also saw compliments in the form of thank you cards and letters which included 'Thank you, we will always be grateful for the genuine care you gave both mum and to us'; 'We will be forever grateful for the very kind yet professional way you cared for (person's name) during her stay.' and 'The care (person's name) has received has been exemplary; she has been treated with patience, respect and genuine love.' One relative said "They look after him very well. I wouldn't want him anywhere else". A district nurse said "Staff are very kind to the residents and they are working very hard."

Staff were able to describe people's preferences and how to support them in a caring meaningful way. For example, they described how one person was a late riser and therefore they respected this. We also observed one person being supported to move by staff who showed patience and compassion when helping them.

Staff knew people well and chatted to them about things that interested them. They also knew people's family and described how they liked to make the family feel at home as well when they came to visit.

At lunchtime some people were supported to eat. This was done by staff who sat beside the person, making eye level contact, talking to the person in a cheerful manner and helping them to eat using an unhurried and careful approach.

People and their families said they were involved in developing care plans and making decisions about the care they needed. Friends and family were welcome to visit throughout the day and evening. One relative

said they sometimes joined their family member for a meal at the home, which staff were always happy to provide.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was personalised and responsive. Staff were not always responsive to people's needs and wishes. This was largely because there were not enough staff available for the number and needs of people living at the service. This meant that staff could not respond to people in a timely way. For example, one person had had pressure damage to their skin in the past, although this had healed. However, this meant they could be at risk of pressure damage again. The person's care plan stated they moved independently, and walked occasionally. However, this information was not up to date as they could no longer walk independently. The person had been supported by staff to go into the lounge at around 11.00am. The care staff used a hoist to move them safely to the chair. At lunch time, staff helped them to sit up in the same chair. We observed that they had not moved from the chair or been taken to the toilet by 3.00pm. This put the person at increased risk of pressure damage to their skin because they had continence issues. Staff told us that, because of the staffing levels, they had to prioritise those who needed to be turned in bed on an hourly basis. This meant staff were not responsive to this person's needs which increased the risk of harm to them.

Another person who was unable to communicate verbally, made it clear by their actions over the course of half an hour that they wished to get up from their chair in the lounge. They were unable to do this without two staff supporting them. However, although this was noticed by a member of staff who said they would get another member of staff to help them move, this did not happen. The person was later supported by staff to eat their lunch in the same chair. They were not asked where they wished to eat their lunch, although their care plan described how they enjoyed eating in the dining room and benefitted from the social interaction with other people. When asked why the person was not eating in the dining area, the staff member said they did normally eat in the dining room. They also said it may be because their mobility was not good that day or they had chosen not to go into the dining room.

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

Although there were charts in care records for staff to record people's weight and fluids/food intake, these were poorly completed and not reviewed. For example one person's care plan described the person as having gained weight in January 2016. However it was not clear from the current care record what their initial weight was, how much weight had been gained or what their goal weight was. A comment in the care plan described that staff should 'observe eating patterns to ensure weight doesn't climb any further.' There was no evidence that the decision had been made with the person's involvement. In March 2016, the person had gained further weight. A comment beside this weight entry stated 'staff to observe [person] weight and eating patterns.' However an entry in April 2016 just recorded 'eats well' although there had been a weight loss of over three kilograms.

Some people were at risk of developing pressure ulcers. These people had charts for staff to record when they had been turned. Other people were or at risk of malnutrition or dehydration. There were food/ fluid charts for staff to complete for these people. However these charts had not always been completed fully. This meant it could not be confirmed if people had received the sufficient food and drink to ensure they

remained nourished and hydrated.

There was a lack of a consistent approach by staff. For example it was unclear if people were having regular baths or showers. The records did not show that this was happening on a regular basis, although staff said that people were offered baths regularly. Some records did show that people were offered but had refused baths or showers, but others contained no evidence of whether the person had had or refused a bath/shower. However, one person said they had asked to have their hair washed but staff had not supported them with this. We discussed this with a senior member of staff who said the person paid to have their hair done by a hairdresser, but sometimes refused this as there was an associated cost. However their care records did not record whether they had been offered alternatives such as a hair wash by staff.

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

The home also provided a day service for five or six people on weekdays between 8.30am and 3.30pm. These people were supported by three day care staff, who ran activities in the larger lounge and dining room. The day services staff also provided support for people living at The Priory. This included helping people to eat their meals and helping them to go to the toilet when necessary.

The day care staff arranged activities within the home on a daily weekday basis. These included armchair exercises, art and craft sessions, a quiz, visiting musician sessions, a visiting helper and their dog, board games such as Scrabble, memory games, dominoes and bingo and sing-along sessions. The home also arranged for a local church to provide a religious service on a monthly basis. People living in the home were able to get involved with these activities if they chose. There were trips out for people. For example, in between the two inspection days five people had gone to the theatre. Other trips that had taken place included visiting a local garden centre, a boat trip and the seaside.

One care worker carried out a quiz with approximately 14 people in the main lounge. They engaged well with everyone and people seemed to enjoy themselves. On another occasion, a sing-along session was held in one of the lounges. However, the songs were being played through the television which most people in the room could not see easily. Two people were singing along, but the other people in the room were either asleep or not engaged. Staff were in the lounge but did not interact with people to check whether they wished to get more involved. However, we did see staff talking to people throughout the inspection. For example, one of the provider representatives was asking people in one of the lounges what they thought about the European referendum, because it was on the news.

We asked how staff supported people with their social and emotional needs if they spent most of the time in their bedrooms. One care worker explained that one person liked to have classical music played on their radio and they always made sure this happened. We found this to be the case. One person said they did not enjoy the group activities so preferred to stay in their room.

Although people were encouraged to get involved in these group activities, we did not find evidence that people were supported by staff to do individual activities of their choice.

Where people or families had made complaints, these were recorded with actions taken to investigate and resolve any identified issues. Where care did not meet the person's expectations, the registered manager wrote to the person and their family to formally apologise and to say what they had done to mitigate the issue occurring again. There was also a log for staff concerns with actions of how these had been resolved. If there had been an issue with a member of staff's practice, one of the assistant managers would usually

provide weekly supervision with the staff member to address the issues. The assistant manager said this was not always recorded, but during their formal one to one supervisions, issues of practice were often discussed and documented. Information in supervision records supported this.

People were able to contribute ideas and share their experiences with staff at resident meetings. We were shown minutes of two resident meetings held in August and December 2015. However, it was not possible to identify whether improvements which had been suggested about people's laundry in August 2015 had been actioned and were effective. The registered manager said they would ensure that future meetings were more formally minuted to show that actions had been completed.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was also the registered provider. She said she visited the home for five or six hours on three or four days each week and had overall responsibility for quality monitoring and the running of the home. They said they spent some time working in the office and also spent some time in downstairs communal areas of the home. They said, due to a physical disability, they were unable to access some parts of the home and relied on staff for feedback about these areas and the people who had bedrooms on the upper floors.

There were two assistant managers who oversaw the day-to-day running of the shifts. They both usually worked between Monday and Friday. In a recent manager meeting minutes, it was recorded that both assistant managers had been covering shifts to ensure care and support was being delivered. This meant their managerial tasks, which included updating care plans and risk assessments had not been completed. Senior staff and the registered manager confirmed that this had been the case. The registered manager and assistant manager both said they knew they needed to give priority to the areas of managerial work that had not been covered due to staff shortages. We found no evidence that the registered manager had taken action to support the assistant managers in respect of the lack of management time for them.

Although the registered manager described the steps they were taking to recruit new staff, they had not adequately considered the impact of low staffing levels on people's wellbeing. On the first day of inspection, we discussed with the registered manager our concerns about staffing. We were told that there were only two care staff on in the afternoon and were concerned that these staff were expected to not only care for people, but also serve and clear away the evening meal and administer medicines. After the inspection, we analysed the staffing requirements during the evening period of 7pm to 10pm using information provided by a senior member of staff. We were told there were two waking staff on duty each night from 7pm to 7am the following morning. We were also given information about each person, including their usual bedtime, the number of staff required to support them to get to bed and the length of time this took. The analysis showed that two staff were insufficient in the evening. We discussed our findings with senior staff and the registered manager. They said they had not done such a detailed analysis and therefore were not aware that staff were not able to provide sufficient care and support to all the people in The Priory during these hours. After the inspection, we were informed that a dependency tool was being used to help calculate staffing requirements.

Quality assurance systems had not always been fully completed. There was a programme for regular quality checks and audits established to ensure the environment was safe. However some of these had not been carried out in recent months. For example checking water temperature to ensure it would not scald people had not been recorded since July 2015. The registered manager said on the first day of inspection, this was unlikely to be the case and agreed to check their records to see if they had been recorded elsewhere. However we did not receive confirmation that they had found this to be the case. There was no evidence that the environmental audits had picked up issues such as the laundry floor being made of a permeable concrete. The poor repair and cleanliness of some of the armchairs in the lounges had also not been identified. The fire door did not have a door handle on it, although this was rectified after we raised it with

staff.

There were no bed rail checks completed for March or April 2016 and records of wheelchair checks were not available after September 2015. Incomplete records of such audits meant the service could not be assured people were safe. The registered manager said she had delegated these types of checks to specific staff, but there did not appear to be a system to check these audits had been completed.

We found evidence of information in care records being incomplete. Charts to record people's weight and when they had been turned in bed had been only partially completed. Although the registered manager said there were systems in place to audit care records, there was no evidence that these audits had identified these issues or that she had addressed these gaps with staff.

Some records were untidy and difficult to review. For example, we asked to see records relating to one person's weight for the previous six months. Staff said that some of the earlier information had been archived. They gave us a sheaf of loose documents which had been stored in the office. These not only contained information about the person, but also information about another person living in the home. The papers were not presented in an orderly manner which meant it was not possible to find any information leading to a decision that the person needed to lose weight.

The registered manager said she took a sample of files and records each week to review and audit. Although she said issues were fed back to the senior team and staff, there was no evidence that the registered manager had taken action to address the issues relating to staff. For example there was no record of how the issues of incomplete training and missed supervisions had been addressed.

Although senior staff were aware of alleged incidents of abuse, there was no evidence that they had followed the organisation's policy in terms of dealing with the matter. This not only included reporting it to the local authority but also taking disciplinary action where appropriate and recording the events on the staff record.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
There had been some care plan audits which had accurately recorded concerns and follow up actions. There were also completed monthly medicine audits. The registered manager audited accidents and incidents to see if there were any trends.

The provider said they were aware of any events that needed to be notified. However, although the provider had submitted some statutory notifications to the Care Quality Commission over the previous 12 months, they had not submitted notifications in relation to incidents of alleged abuse. A notification is information about important events, which the provider is required to tell us about by law. The registered manager had also not made a safeguarding alert to the local authority. This did not follow the home's own safeguarding policy.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009
People and their relatives had regular opportunities to have their views heard and be involved in the review of the quality of care and support provided. Surveys were sent each year and responses were collated and analysed to identify themes and take appropriate action. The surveys were usually sent to people and relatives each June. Following last year's survey, where a number of people said they were not aware of how to make a complaint, the registered manager had moved the document describing the complaint process to a more prominent place in the home. It was now placed near the entrance hall next to a suggestion box.

The registered manager said they promoted an ethos of providing a homely environment for people. The compliment cards supported this. Comments included ''(Name of relative) was immediately made to feel at home and part of the Priory family and we as part of the extended family."

Several staff said they had worked at the home for a number of years and felt a loyalty to the people living there. However, one member of staff said the reason they stayed was their "conscience" rather than job satisfaction. They described how the staffing issues had had a major impact on their work.

Staff were able to provide feedback at staff meetings, supervision sessions and in handover meetings between shifts. Care staff told us they felt supported by the registered manager and the assistant managers. One care worker said "They are really good employers". One relative said "The registered manager is very approachable. She sorts things out, things are acted upon."

The registered manager kept up to date with regulatory changes. They also were members of a Devon group which provided support and updates to residential homes.

There were policies and procedures in place to guide staff, which were regularly reviewed and updated. Staff records contained evidence to say that staff had read the policies.

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 18 Registration Regulations 2009 Notifications of other incidents Statutory Notifications had not been sent to the CQC when there were allegations and incidents of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's individual needs, as described in their care plans, were not always taken into account when care was provided by staff. People's needs were not always met in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was no written evidence to show appropriate actions had been taken to deal with allegations of abuse appropriately. Allegations had not been reported, as required, to the local authority or to the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydrations needs were not fully met,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There were infection control risks in the laundry including the flooring and areas of flaking paint. Some chairs in the lounges appeared to have engrained dirt on the arms.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Checks to ensure that new staff were suitable to work with vulnerable people had not always fully completed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and contemporaneous notes of the care provided to people were not fully maintained. Staff had not always followed the provider's policies and procedures. Checks and audits of the home and the care provided had not always identified issues. Where issues had been identified, there was no evidence that actions had been taken to rectify them.

The enforcement action we took:

Served Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's needs and keep them safe at all times. Some staff had not completed training to ensure they had the skills and knowledge required to meet people's needs.

The enforcement action we took:

Served Warning Notice