HC-One Oval Limited

Alexandra Care Home

Inspection report

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Date of inspection visit:
07 November 2018

Date of publication:
25 March 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection visit took place on 7 November 2018 and was unannounced. It was completed by one inspector, an assistant inspector, a nurse specialist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

Alexandra is a care home registered to support 39 people. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection 37 people were living at the home.
The accommodation is provided over two floors. The ground floor has a large dining area which has access to the outside space. There is also a large activity living space which also has access to the secure garden. Each floor has bedrooms with ensuite facilities with additional communal bathrooms. The upstairs is divided into to two areas, one has a lounge/dining area. The other has just bedrooms.

Since our last inspection in November 2017, the home has been transferred to a new provider, who retained the registration. This was the new providers first inspection at this location since their registration with us in December 2017.

There was a registered manager at this location. 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. This registered manager has remained constant from the homes previous registrations with other providers.

The governance of the home was insufficient to ensure that people received support to keep them safe and maintain their wellbeing. Audits had been completed, however were not always used to develop the quality and drive improvement. Partnerships had not always been developed to enhance the care available to support people and the staff.

There were not always sufficient staff to support people. The staff had not all received training in the areas they needed to support their role. The provider had not ensured that people were always protected from the risk of infection. Staff did not always feel supported by the registered manager.

Risk assessments had been completed, however for some areas of care the correct guidance had not been

followed. Lessons had not always been learnt to drive improvement.

The environment had not been adapted to support those living at the home and the environment was in need of redecoration. We have made a recommendation that the provider looks at current guidance in relation to the environment for people living with dementia.

People were not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. We have made a recommendation that the provider looks at current guidance in relation to supporting people to make decisions.

When people received care, it did not always respect their dignity. People did not always receive the support to make choices and be active in their decisions. These were not supported by documented information. Care plans did not always include people's preferences, cultural needs and life history.

When people's needs changed this information was not always clearly communicated to ensure the care reflected people's current needs. People's wishes and needs had not always been included for their end of life care planning.

Some people required different communication methods and these had not been considered to ensure people had the information available to them.

People's views had not always been considered and some improvements had been made. Relatives were welcome and people were supported to following their religious faith.

When people received care, staff made every effort to support people in a kind way. People enjoyed the meals and had been supported to have their health care needs met.

Medicine was managed safely and people received their medicine as prescribed. The registered manager had completed notifications. Complaints had been addressed and suitable recruitment processes were followed.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

There were not always sufficient staff to support peoples care requirements. People were not always protected from the risk of infection. Risk assessments had been completed, however for some areas of care the correct guidance had not been followed. Lessons had not always been learnt. Medicine was managed safely and staff understood how to raise a safeguard. Safe Recruitment processes had been followed.

Is the service effective?

Requires Improvement

The service was not always effective

People were not always supported with the right assessment to ensure decisions had been made in the persons best interest. The environment had not been adapted to support those living at the home. Staff had not always received the training and support they required for their role.
People enjoyed the meals and had been supported to have their health care needs met.

Is the service caring?

Requires Improvement

The service was not always caring

People's dignity was not always maintained. Some people did not always receive the support to express themselves and be active in their decisions.
When people received care, staff made every effort to support people in a kind way. Relatives were welcome and spiritual needs had been considered.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans were not always detailed to include people's preferences, cultural needs and life history. Information was not always clearly communicated to ensure the care provided was in line with changing needs. People's wishes and needs had not

been included for their end of life care. Different communication methods had not been considered to ensure people had the information available to them. Complaints had been addressed

Is the service well-led?

Inadequate

The service was not well-led

The atmosphere was not homely and in need of redecoration. Staff did not always feel supported. Audits and quality information had not been used to drive improvement. Partnerships had not always been fully developed to enhance the care available to support people and the staff.

People's views had not always been considered, and some improvements had not been made. There was a registered manager who completed notifications and had displayed the last rating for the home.

Alexandra 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The provider had completed a Provider Information Return as part of the Provider Information Collection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we collate about the service, such as notifications the provider had sent to us about significant events at the service. We also reviewed the quality monitoring report that the local authority had sent to us. All this information was used to formulate our inspection plan.

Not everyone in the home could tell us about their experience of their life in the home, so we observed how the staff interacted with people in communal areas. However, we were able to speak with five people and five relatives to receive their feedback on the quality of care received. We also spoke with four members of care staff, a member of the domestic staff, two senior care workers, two nurses, the deputy manager and the registered manager. We spoke with the area director and area quality director who were also present for the feedback at the end of our inspection. After the inspection we contacted the Macmillan End of Life Care Facilitator and the Advance Nurse Practitioner by email for their perspective on the home.

We looked at the care records for six people. We checked that the care they received matched the information in their records. We looked at a range of information to consider how the home ensured the quality of the service was continuously reviewed; these included audits relating to accidents and incidents, infection control audits, complaints, compliments and surveys to reflect feedback. We also reviewed the records for recruitment to ensure staff employed by the provider had received the correct checks for their suitability to work with people.

After the inspection we asked the registered manager and area director to share some documents in relation to the quality of the home. These included the training records, audits in relation to falls, incidents

and infection control. We also requested minutes from meetings held with staff. We received the information as requested and have included the details in our findings.

Requires Improvement

Is the service safe?

Our findings

We reviewed care plans for people who had been identified as being at risk to themselves and others due to their anxieties or behaviours. One person's behaviour chart stated that staff had used 'reasonable restraint' during an incident. Within the behaviour plan there was no guidance as to what this entailed and staff had not received any training in this area. Records showed that on some occasions the person was supported with some restraint from staff, when this occurred the details were recorded as an incident not as restraint. However, guidance reflects that when restraint is used this should be recorded in a specific way. The registered manager told us staff did not use restraint, they used distraction techniques. Another person's behaviour plan was detailed 'to give the person anxiety reducing medicine' this was before the guidance considered distraction techniques. We saw that this person had received behaviour medicine and it was unclear if this was before distraction techniques had been considered. This meant we could not be assured that the behaviour plans reflected the needs of people or had followed current guidance 'Positive and Proactive Care, reducing the need for restrictive interventions'.

For some people a behaviour plan had been completed, however staff had not always seen these which meant that people were not always managed consistently. For example, one staff member told us if they saw someone being anxious or displaying behaviours they always started the conversation with, "How are you today?" They had no knowledge of any techniques or distraction to be used. One person shouted in distress when they received personal care. When we spoke with staff the response was, "They always make that noise when we do personal care." No strategy had been put in place to consider how they could relieve this person's anxiety and reduce the impact the noise had on others in the home.

One area of the home focused on caring for people who were nursed in bed, however two of these people were more active. These people were moved to other areas of the home during the day. However, how to manage their behaviour had not been cascaded to the staff in these areas. The other person's care plan stated, 'They become agitated and unable to tolerate noise,' however they were moved to an area which had people who expressed themselves through their behaviour and this was frequently through loud noises. Moving people living with dementia can instigate stress and disorientation when changing living environments. This meant we could not be sure people's individual needs had been considered or how their support should be provided.

In addition, in this area of the home, daily checklists for personal care had been completed with very few omissions. The fluids were totalled each evening, however individual targets, had not been always been recorded. This meant we could not be sure the record confirmed if the person had received the required amount.

Some people had a catheter in place which required staff support. However, we found this was not always provided in line with current guidance, Care and Management of Patients with Urinary Catheters. For example, some people did not have the required support straps in place for their catheter. Another person only had one in place. Leg straps prevent tubing and leg bags from catching or pulling from regular

movements. In the summer the Advance Nurse Practitioner (ANP) told us they had raised the concern with the deputy manager advising them to contact the continence advisory service to update staff on the correct guidance in catheter care. However, this had not been followed up and the ANP has raised this as an ongoing concern to the home and with us during the inspection. This meant people were not receiving the correct care and were placed at risk of possible infections.

One person had restrictions placed against them following an assessment relating to them being a high risk of choking. These restrictions related to the person eating in their room under supervision. However, one of the other restrictions was that food could not be brought into the unit whilst this person was about as staff were concerned the person would take the food from others and place themselves at risk. There was no best interest decision to consider the needs of the individual and the impact on other people receiving responsive care and being able to access snacks in a homely environment.

The associated risks of the prevention and the control of infection had not always been recognised and action taken to prevent and control the risks. Overall, the home's communal areas were clean, however some areas were of concern. A shower room on the ground floor which had been used on the day of the inspection and was confirmed by staff as having been used daily, had drainage problems. The water did not drain away, leaving stagnant water on the floor and there were missing and broken tiles on the wall. These created a potential injury hazard and an infection control risk as this area could not be cleaned to the required standard. At our request this shower was taken out of commission on the day of the inspection.

The upstairs shower room also had concerns as it had black mould behind the tiles. Both shower rooms had been identified as requiring a refurbishment, however no interim arrangement had been made to provide safe facilities for people's personal hygiene to be met. In addition to the issues with the showers, one of the bathrooms was also out of operation which had restricted the facilities available to people. One relative said, "They give [name] a shower, but they like a bath, but that is not offered." The regional manager advised us that the shower rooms would be repaired as a matter of urgency and confirmed the work would commence within the next two weeks.

Some toilet facilities we observed had some staining. Due to the home not having any cleaning schedules available we could not be sure when that facility had last been cleaned. In all the bathrooms we observed toilet brushes were in use and were worn. The Prevention and Control of Infection in Care Homes guidance details how infections can be transferred and toilet bushes are a potential source of cross contamination and should either not be used or replaced regularly.

We observed one person's bedroom had provided a challenge to the domestic staff as this person was reluctant to leave their bedroom which restricted when it could be cleaned. The smell from the room was evident along the corridor and the lack of consistant cleaning could be an infection risk to both that person and other people in the home.

Lessons were not always learnt from incidents. For example, when people's behaviour required an approach this was not shared with all the staff, and when the bathroom was identified as being unsafe for use, it continued to be used.

This demonstrates a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
There were not always enough staff to support the needs of people. The home is divided into three units and the staff were allocated to support people when they commenced their shift. One unit, identified as 'the short corridor' was supporting nine people with two staff during the day. Seven people remained in bed and

required repositioning by two staff, at least every four hours and for two people every two hours. Staff told us they were task driven. One staff member said, "We literally go from one person to the next just making sure they are clean and they have had some food or drink, there is no time to be with them for any social interaction." It required two staff to support each person, whilst this care was being provided there was no one available in case another person required support. During mealtimes all seven people [two people had moved to other areas] required support. Some additional support was provided by the kitchen assistant. However, people still had to wait for their meals. Staff would give one person their main meal and then move onto the next person and then return later with their desert. This doesn't support a person centred model of care.

All the staff we spoke with raised concerns about the levels of staffing. One staff member said, "Some days some people require one to one support and there is not enough of us." Another staff member said, "We regularly work below the staffing numbers." Further concerns were raised about the staffing levels at night. One person told us, "There doesn't seem to be that many people around at night. I don't know how many are here, but that's when I wait a long time." The providers schedule identified the need for four care staff and a nurse each night. Staff told us they frequently work below these numbers. For example, the weekend just passed there was only three care staff on duty. Another staff member told us, whilst they were completing their induction on three occasions there were only three care staff presents. Staff said, "Even with four care staff we struggle, we have people who require two staff and some people are awake through the night, it's not safe." The registered manager confirmed they had worked below their required numbers at the previous weekend and on other occasions. This meant the provider had not always ensured they met their allocated numbers for staffing levels.

Staff knew how to keep people safe and protect them from safeguarding concerns. One person said, "I feel very safe as the staff look after me really well." A relative said, "My relative is very safe here and the staff are brilliant." Staff were trained in safeguarding and able to identify how people may be at risk of harm or abuse and what they could do to protect them. In addition, staff were aware that the service had a safeguarding policy to follow. We saw that safeguarding concerns had been raised and had been investigated.

People's medicine was managed safely. One person said, "The nurses bring my tablets and a drink of water and wait until I've taken them." Another said, "I don't know what the tablets are, but staff bring them in the morning, at lunchtime and at night." We saw that the home had a single point of contact with the pharmacy. The nurse said, "This works well." A stock check was completed weekly which meant staff were aware when medication was limited in stock and when they needed to order more to meet the prescribed need. Room and fridge temperatures were recorded daily to ensure medicine was kept at the required temperature to maintain its integrity. When medicine was required for pain or anxiety there were protocols are in place. These were detailed and had been reviewed.

Mostly the medicine was dispensed and administered by the nurse, however some senior care staff had received training to administered medicine. They received training which included the completion of a booklet. Following this they received three observations facilitated by nurses to check their competencies. There is a requirement that nurses revalidate their nursing registration with the Nursing and Midwifery Council every three years. We saw this was monitored and nurse's registrations were up to date.

Other risk assessments had been completed to reflect when there were areas of concern. One person said, "I can manage on my own. I just need a bit of help when I get dressed and the staff are very good about helping me." We observed people being transferred using equipment and this was done safely. Staff were careful and constantly reassuring the person throughout the transfer.

People were supported to keep safe in the event of a fire or other emergency that required their home to be evacuated. Plans were in place to support staff in responding to emergencies, such as personal emergency evacuation plans. The plans were updated at regular intervals and provided information on the level of support the person would need in the event of fire or any other incident that required their home to be evacuated.

We saw that checks had been carried out to ensure that the staff who worked at the home were suitable to work with people. These included references and the person's identity through the disclosure and barring service (DBS). The DBS is a national agency that keeps records of criminal convictions. One member of staff told us that they had to wait for their DBS check to come through before they started working. This demonstrated that the provider had safe recruitment practices in place

Requires Improvement

Is the service effective?

Our findings

Staff had not always received the training they required to support their role. People living at Alexandra often experienced behaviours which placed themselves and others at risk. In the PIR the provider told us, 'Staff have training in behaviours that challenge, both theory and practical breakaway techniques.' However, not all the staff we spoke with had received training in this area or in supporting people living with dementia. One staff member said, "We have some people with specific conditions and I have not received training in how best to support them."

We reviewed the care plans for these people and noted there was detailed information to reflect the person's preferences and care needs. However, the registered manager confirmed no formal training had been provided for this condition to support staff. This sentiment was shared by the majority of staff we spoke with. Another staff member told us, "Most of the training is online and there is no opportunity to do this at work. So, we have to do it in our own time." In addition, it was identified that not all the courses had been made accessible to the staff to complete. We reviewed the training information, this showed that of the standard courses only 60 % had been completed. Further analysis showed that less than 50% of the staff had completed the training in infection control and less that 40% in equality and diversity. This meant staff had not always completed the training required to support them in their role.

When staff commenced their role, they were guided to complete the online training and to have shadowing experience with established staff. However, staff we spoke with said that the shadow shifts didn't always happen. One staff member said, "I was included in the numbers after one day."
New staff had not always been supported through a structured probation period. Newly registered nurses who had been employed, were not given the structured transition as a newly registered practitioner in accordance with their post qualification requirements. This meant new and existing staff were not always provided with the support they required for their role.

This demonstrates a breach in Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

We checked whether the provider was working within the principles of the MCA. Decision specific assessments had been completed, for one person there were fourteen assessments and these were all identical in their content with the exception of the decision. Where a relative or professional had been

identified it was unclear how their input had influenced the decision. This meant that we could not be sure that each decision had been considered with the appropriate contacts or how the decisions had been made in the person's best interest.

We also saw that one person had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), the provider had not considered how this decision had been made. There was no capacity assessment or detail to show how the decision had been made. The form identified that an advocate had been involved and that a best interest meeting had been held, however we could not identify these links within the care plan. When we asked the deputy manager, we were told the form had not been completed correctly, as the person had not received support from an advocate and there was no clear evidence of a best interest meeting taking place. Advocates are either lay advocate or statutory advocates, for example Independent Mental Capacity Advocates ('IMCAs') and Independent Mental Health Advocates ('IMHAs').

All the people currently in the home had been referred for a DoLS, we saw some had been authorised and others were with the local authority awaiting authorisation. However due to the MCA assessments not being completed in accordance with guidance we could not always be sure all the restrictions the person may be subjected to had been included. For example, when people had bed rails in place.

Some staff we spoke with had an understanding of MCA as they had received online training, however others despite this training were not always clear about MCA and the impact that had on people and the care they provided. One staff member said, "I assume everyone is on a DoLS and they all have assessments."

We saw that staff generally asked people for consent and explained what they were doing before commencing the task. One person said, "They are always asking me. I'd soon tell them if I didn't like anything." However, during the mid-day meal, we observed some people being given clothes protection against their wishes. We saw a staff member approach a person, saying, 'Come on [name] here's your pinny.' The person replied, 'Show me some respect.'

We recommend that the provider seeks advice on best practice, to assess people's capacity in relation to specific decisions for people living at the service.

The home mostly supported people living with dementia or people who had nursing needs. The environment did not support the needs of these people and had not been adapted accordingly. There were three large posters displayed on the wall identifying that each person had a memory box outside their room to provide information about the person and enable them to identify their room. We saw none of the bedrooms had a memory box in place. All the doors on the downstairs corridor were identical and there was no dementia friendly signage, to provide clues for people to the function of the rooms; for example, toilets, lounge or dining area. This meant people may be limited in being able to orientate themselves around the home.

The two areas upstairs were named, 'short 'and 'long' corridor, this is not welcoming and doesn't support a model of care to be personal or homely.

We recommend that the provider considers current best practice in relation to the environment to support people living with dementia.

The home had an accessible secure garden, which had a flat pathway which winded around the flower beds. There was also seating and a covered area to protect people from the extremes of weather. Staff told us they had really enjoyed time with people in the garden this summer. One staff member said, "It's been lovely and

people's behaviour seems to have reduced and their sleeping patterns were more settled."

In the PIR the provider told us, 'Staff have to anticipate people's needs and ensure frequent drinks and snacks are offered.' In addition, we also saw this was mentioned in the June 2018 meeting reminding staff to offer people regular fluids. However, we saw the drink trolley was at 11.00 am and 3.00 pm. One family member told us, "We were assured that they get drinks every 30 minutes, however we never see that and we visit daily for long periods."

People enjoyed the meals they received. One person said, "The food is very nice." Another said, "I think there are a few different things. Biscuits were offered in the morning and there was fresh fruit on the trolley and cakes in the afternoon.

We discussed the menu with the head chef. They told us they had recently had a meeting with other chefs in the providers portfolio and that it had been useful. From the meeting a new board had been developed to identify the different dietary requirement for people. They had also introduced a book which reflected each person's dietary needs and preferences. Although the provider had a set four weekly menu, the head chef told us they were able to be flexible with the menu to accommodate people's needs. For example, most of the people required a diet which was softer in texture, the menu had been modified to support this. The head chef told us, "I have discussed these challenges with the provider and they have agreed to look at the menus."

People in the downstairs dining area enjoyed a positive meal experience. Tables were laid with serviettes and condiments were available. Lunch was not hurried, and people could take as much time as they wanted. Some people required support with their meal, this was done quietly and kindly with staff members focussing on the person they were helping.

People's ongoing health care was monitored. One relative said, "They tell us straight away if [name] is off colour or anything." Another family member said, "Staff always get in touch with the family if [name] is unwell or they are worried about them." We saw that each week the home received a weekly visit from the ANP. These visits enabled any concerns to be raised and ongoing health care needs to be monitored.

We saw when people's health care needs had changed referrals had been made to a range of health care professionals. For example, when people had changes in swallowing they would be referred to the Speech and Language team as required.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always maintained. We observed two situations during the day when people were left in wet clothes for a longer period than would be acceptable for comfort. During one of these periods the person sat on several chairs which were not cleaned when they moved. We saw other people then sat on the wet chairs prior to any cleaning.

People told us that staff respected their privacy and dignity and we saw that staff were careful to close toilet doors when assisting somebody. However, we saw one person who was not feeling well being given a vomit receptacle in the main lounge. Nobody asked them if they wanted to remain there, or supported the person to be somewhere more private.

This demonstrates a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of the need to provide person centred care, enabling people to sleep in if they wished or to have their care delivered at a time which was right for them. For example, showering in the afternoon. However, due to staffing numbers the staff told us that this impacted on the care delivery for others. We observed that at 3.00pm drinks were not given as the staff were delivering personal care to one person who had slept in and no one else was available to support them. People then had to wait until the teatime for further refreshments.

During the inspection it was clear that staff who had been at the home for some time knew people well. Care staff interacted in a kind, gentle and warm way with people. We observed a staff member kneeling at the side of one person whilst talking to them ensuring that they could hear what they were saying and to be at the same level.

People told us they liked the staff. One person said, "They are very good. They do help me to get dressed. I pick out what I want to wear, and they are very gentle." We saw that interactions between staff and people were very warm and friendly. There was also some friendly banter, staff clearly knew who they could have fun with and who would not be happy with this form of interaction. One relative said, "Staff know when to use humour to defuse situations." We received the following comment from people about staff, 'They are marvellous. Nothing is too much trouble for them,' 'They're all very nice with us.' And, 'They are smashing.'

Family members we spoke with told us they felt welcome. One relative said, "The staff here are really good. It's very relaxed here." We saw one visitor had come with their dog and people enjoyed the interaction. A relative said, "The staff are really good. I come every day and I've seen nothing but kindness towards people here."

In the PIR the provider told us they support people to practice their religious faith. People told us they enjoyed the songs of praise service which was delivered every month. In addition, they could have individual

prayers and spiritual needs with the local Anglican vicar.

Requires Improvement

Is the service responsive?

Our findings

People were not always fully supported at the end of their life (EOL). The registered manager told us when people were EOL they received a detailed EOL booklet, which superseded the existing care plan. One person had declined in health, they were receiving palliative care, however the EOL booklet had not been completed. Care plans are important to ensure that people's last wishes and preferences had been considered and where possible supported. People's pain relief and management should also be documented to facilitate a dignified and, if possible a pain free death.

Not all the nursing staff we spoke with had received EOL training to consider how to provide the best care for people, including how to they should receive their pain relief. We discussed this with the registered manager. They told us they had linked with the EOL team in Derbyshire for support. We contacted this team who told us, that over the last year there had been no contact made. The evidence we found meant we could not be sure that people would receive the care they require when they neared the end of their life.

The provider did not ensure that people were supported with their autonomy. Some people on the 'short' corridor required specialist chairs, this was to enable them to get out of bed and sit and be in a different position. The people had to take it in turns to sit in the chairs and this decision was managed by the staff. When people required a specialist chair, this should be bespoke to the individual, this to ensure that it is not restrictive and to reduce the risk of infection.

People's historical information relating to their life and interests had not been reflected in their care plans. The development of this information would encourage understanding of people's life and could reflect in some cases why and how people reacted. This information is invaluable when developing person centred care plans and supporting people living with dementia, along with how to shape activities or sensory stimulation.

Staff told us they did not have time to read care plans and relied on handovers and the information on the white board in the office. However, when staff commenced their shifts they were not always given information about any changing needs of people. One staff member said, "We usually get a handover in the morning; however, we rarely get one at 2.00pm. We did not get one today." We reviewed the handover notes completed for the last week. Staff told us the form they used only considered 'significant events'. This wording had different interpretations for each staff member. Some 24-hour periods had no details completed about any people. The nurse told us they talked through the white board in the clinical room. Staff were expected to record their own notes about people during the handover. We discussed this during feedback and the managers told us they would review this process.

All the bedroom doors downstairs were locked when people were not in them and most of the people were guided to spend their day in the communal spaces. We spoke with the registered manager about this and they told us, this was to prevent people entering each other's rooms. However, this also meant that people who wished to were unable to enter their own rooms unless they alerted staff. This meant we could not be

assured that people's restrictions had been considered and the appropriate assessments and decision process had been followed.
The provider had not considered how to address people's needs under the Equality Act 2010. Assessments did not include people's country of origin or reflected their culture or any individual aspects of care in relation to diet or local traditions.

People had not been supported with information or different methods of communication. The Accessible Information Standard requires providers to consider how information or communication needs relating to a disability, impairment or sensory loss. Communication plans did not identify any communication needs. We saw no other methods had been considered, for example, easy read information or picture menus to support choice or objects of reference. This meant we could not be sure people had been supported or encouraged to communicate their needs.

This demonstrates a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People were not always supported to receive social support or stimulation. For example, the low staffing numbers on the 'short corridor' meant that care staff had limited time to spend with people apart from providing personal care support. There was no evidence of any sensory equipment to provide sensory stimulation for people who remained in their rooms or in their bed.

In other areas of the home, activities had been improved upon. The provider had employed a second activities coordinator. A relative said, "There is noticeably a difference with more activities taking place. People are encouraged to take part. I have also seen an improvement in the staff being present in the communal areas where as before this was not the case." Another family member showed with us a letter they had received detailing the programme for Christmas which included a Christmas party, a pantomime and a carol service. One person said, "We have singers coming in. It's nice."

We spoke with the activities coordinator and observed crafts being completed in the morning. People were making paper poppies for Remembrance Day. One or two people were actively engaged. Other people were seated around the table, to absorb the atmosphere. The activities person said, "I try to give different things to people depending on what they like. We do a lot of crafting. Most people like group activities, but there are others who don't like to join in. I also spend one to one time with some people if I have time and just talk about their families and things that have happened in their lives.

Complaints had been addressed. There was a copy of the complaints policy and process displayed in the home. One family member said, "I have not had to raise any concerns, but if I did, I feel it would be addressed promptly and not ignored." We saw that all the complaints which had been received had been responded to. Some complaints had resulted in meetings with family members and included other social care professionals to resolve concerns. All complaints had been responded to in line with the providers policy and any responses provided an apology and an outcome. Some families we spoke with still felt areas of concern had not been completely addressed and we asked the registered manager to review these concerns.

Inadequate

Is the service well-led?

Our findings

People and relatives could not be assured by the vison and values of the provider. The provider has a corporate focus on kindness, quoted as, 'Home isn't just a place, it's a feeling. Feeling happy, feeling valued and respected, feeling as if you can be yourself. Kindness enables everyone to feel appreciated and understood, which in turn makes them feel safe and secure – a part of the family.' This ethos was not fully apparent during our inspection.

Relatives told us that they enjoyed visiting the home. One relative said, "There is generally a very kind and friendly atmosphere in the home between staff and residents." However, we saw people were seated in lounges which were not homely or reflective of an environment suitable for people living with dementia. People were unable to access their own bedrooms and were encouraged to remain in the communal spaces. People's dignity had been affected and staff did not always have the skills to provide the care people required.

In the PIR the provider told us they had introduced a suite of audits and quality measures. We reviewed some of this information during the inspection and afterwards. Given the concerns we identified during the inspection we could not be sure that the audits had been used to drive improvement. For example, we saw that the shower rooms had been identified by the audit by the registered manager as being of concern in October 2018, however no interim measures had been taken to reduce the risks or the urgency raised with the provider. The audit had also stated that staff had received training, however we saw over 50% were still required to complete this.

Incident's had been audited and we could see that each incident had been reviewed for any measures which may be required to be put in place to reduce the risk. However, on analysing this data we observed that when information was completed the person's name often had different spellings. This meant that when reviewed the number associated with the person it was incorrect. For example, one person had three different entries each with one incident, this meant the person had actually had three incidents. Another person had two entries each with three incidents, which meant they were a high risk as they had had six incidents during this period. The information did not always accurately highlight when people were at risk due to the frequency of the incidents they have had. Some people had received advice in reference to their frequency of falls and equipment had been provided.

The provider had not considered the levels of incidents and the time of occurrence to reflect staffing levels. For the period from May to October 2018 there had been 133 incidents. Of these 94 had occurred between 4.00pm and 7.00am. Further analysis showed that 59 incidents had occurred between 7.00 pm to 7.00 am. The provider told us that they reviewed the staffing levels weekly. This included reviewing individual's needs and other factors. However, there had been no increase in staff or reflection on deployment by the provider to correlate between the incidents and staffing levels.

We saw within the PIR, staffing was a continued concern and the provider told us they were using agency nurses and had an ongoing recruitment process. However, we identified there were not always the required numbers of staff to support people and the process when sickness or absence occurred was not suitable to provide staffing reassurances. For example, we were told when a staff member called in sick they had to request permission from the registered manager before they could approach an agency to access staff. One staff member said, "If it is out of hours or they are not here, you can call or leave a message and sometimes it's hours before they return the call, by which time it is often too late to get anyone." Another staff member told us they had raised these staffing concerns with the regional manager and no changes have been made. We discussed this process with the registered manager and they confirmed this was the current arrangement. There was no planned approach to covering sickness to maintain the required staffing numbers.

The registered manager also told us they monitored the staffing training levels, however when we reviewed the training records, courses had not always been completed. This meant that staffing skills had not been monitored and due to the limited supervision staff received this was not reviewed in conjunction with the staff and their required skills for their role.

There was registered manager at the home. There were mixed feelings about the support staff received. Some staff, generally those who had been at the home a long time felt supported by the registered manager. However, some staff felt the registered manager was not accessible and did not have a visual presence in the home. Other comments supported this as staff told us they did not always feel supported or invested in, and some staff informed us they were leaving and cited this as part of the reason. One staff member said, "It's a lovely home with potential. A lot of passionate staff that care, but a lot of us feel we are not supported."

Partnerships had been developed with the ANP from the local surgery and they completed a weekly health round. However, there was a reliance on this relationship to facilitate links with other professionals. For example, one person had been refusing their medicine, the registered manager had waited for the ANP to attend to contact the relevant professional. The ANP told us, "There is a lack of ability to network with the mental health teams." This approach was also reflected when some people came from an acute psychiatric unit. The assessing nurse has not questioned what the follow up arrangements would be for these people should their behaviour becomes problematic. The expectation was that there should be a prearranged plan in place. The partnerships with other health care links had not always been maintained, in respect of EOL care and continence care. This meant we could not be assured that the partnerships were in place to support the staff or the needs of people.

We saw the care plans and daily recordings were kept in separate files and on different floors. For people upstairs, their care plans were stored downstairs. There were individual daily use folders held upstairs, however the details contained in these folders were not always consistent. For example, the dietary needs in one person differed in each folder.

Downstairs we could not be sure that records which were maintained were accurate or reliable. We saw that staff completed the daily logs retrospectively. For example, after teatime staff were completing daily logs. We heard conversations relating to what people, had received to drink or eat earlier in the day. This meant we could not always be sure the daily records had been completed accurately.

In addition, the majority of paperwork within the home did not have a space for the designation of the staff completing the paperwork, which meant the provider would not be able to ascertain who had completed the information and their role within the organisation.

We saw a whiteboard was in use in the clinical room. This displayed people's full name and some personal details. This board could be observed through the windows, one was on the outside of the building the other in the communal lounge. This board contravenes the requirements of the General Data Protection Regulations 2016.

People and relatives had made comments about the home related to the environment, one comment said, 'It is more like a hospital, the cleaning lets it down.' Another said, 'It needs redecorating.' The 'You said we did' board displayed in the home had no information in reference to any of these comments. This meant information had not always been shared with people or relatives in relation to the action that had been taken or any future plans.

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

We saw that relatives feedback had been requested and that meetings had occurred at the home. We saw there was a request for more activities and that the provision for activities had been increased.

The registered manager had notified us of events and safeguard concerns at the home, which enabled us to monitor the actions which had been taken.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care was not personalised specifically provided for each person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always enough staff trained to support peoples needs.

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
Treatment of disease, disorder or injury	The Registered Provider had not implemented effective systems and completed audits to drive improvements.

The enforcement action we took:

Serve an NOP for positive conditions to the provider