Sun Care Homes Limited

The Gables Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 April 2016 and was unannounced.

Accommodation for up to 26 people is provided in the home on two floors. There were 17 people using the service at the time of our inspection. The home provides nursing care for older people.

At the previous inspection on 14 and 15 April 2015, we asked the provider to take action to make improvements to the areas of person-centred care, dignity and respect, need for consent, safe care and treatment, good governance and staffing. At this inspection we found that improvements had not been made and more work was required in all areas.

A registered manager was in post and was present during the inspection. 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.

Staff did not always safely manage identified risks to people. The premises were not always managed to keep people safe. Sufficient numbers of staff were not always on duty to meet people's needs. Safe infection control and medicines practices were not always followed. Staff knew how to identify potential signs of abuse; however, restraint was being carried out by staff and they had not received sufficient training or guidance to do this. Staff were recruited through safe recruitment practices.

Staff did not receive appropriate training, supervision and appraisal. People's rights were not always protected under the Mental Capacity Act 2005. People did not always receive sufficient amounts to drink. External professionals were not always promptly involved in people's care as appropriate. People's needs were not fully met by the adaptation, design and decoration of the service.

Staff were mostly kind but did not always treat people with dignity. People and their relatives were not fully involved in decisions about their care. Advocacy information was made available to people.

People did not always receive personalised care that was responsive to their needs. Activities required improvement. Care records did not always contain information to support staff to meet people's individual needs. A complaints process was in place and staff knew how to respond to complaints.

There were systems in place to monitor and improve the quality of the service provided, however, they were not effective. People and their relatives were not involved nor had opportunities to be involved in the development of the service. The provider and registered manager were not meeting their regulatory requirements.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can

see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Staff did not always safely manage identified risks to people. The premises were not always managed to keep people safe.

Sufficient numbers of staff were not always on duty to meet people's needs. Safe infection control and medicines practices were not always followed.

Staff knew how to identify potential signs of abuse; however, restraint was being carried out by staff and they had not received sufficient training or guidance to do this.

Staff were recruited through safe recruitment practices.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive appropriate training, supervision and appraisal. People's rights were not always protected under the Mental Capacity Act 2005.

People did not always receive sufficient amounts to drink. External professionals were not always promptly involved in people's care as appropriate.

People's needs were not fully met by the adaptation, design and decoration of the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were mostly kind but did not always treat people with dignity.

People and their relatives were not fully involved in decisions about their care. Advocacy information was made available to people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their needs. Activities required improvement. Care records did not always contain information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There were systems in place to monitor and improve the quality of the service provided, however, they were not effective.

People and their relatives were not involved nor had opportunities to be involved in the development of the service.

The provider and registered manager were not meeting their regulatory requirements.

The Gables Nursing 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.

This inspection took place on 25 and 26 April 2016 and was unannounced. The inspection team consisted of an inspector, a specialist nursing advisor with experience of dementia care 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 service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted visiting health and social care professionals, the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with seven people who used the service, five visitors, a housekeeper, the maintenance staff member, a laundry staff member, three care staff, one nurse and the registered manager. We looked at the relevant parts of the care records of seven people, three staff files and other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

During our previous inspection on 14 and 15 April 2015 we identified that risk assessments and guidance to manage risks were not always in place. At this inspection we found that improvements had not been made and work was required in this area.

Risks were not always managed so that people were protected and their freedom supported.

Pressure ulcer risk assessments had been completed monthly and care plans indicated that steps were being taken to control the risk, such as the use of pressure relieving mattresses, cushions and people were assisted to change their position regularly. There were pressure relieving mattresses and cushions in place for people at high risk of developing pressure ulcers and they were functioning correctly, however, they were not always set to the correct weight of the person who used the service which placed those people at risk of avoidable harm.

Moving and handling assessments and nutritional risk assessments had also been completed monthly. However we had some concerns about the accuracy of the risk assessments. For example, a person's risk assessment indicated the person walked frequently when other parts of the care record and our observations confirmed that the person was being transferred using a hoist.

Where bed rails were being used to prevent people from falling out of bed, a risk assessment had been completed to ensure they could be used safely. However, one person's daily bed rail check form (to ensure they were safe to use) had not been completed regularly with a gap of almost two months between recordings. This meant it was not clearly documented that staff had checked to ensure that bedrails remained safe to use to ensure people were not placed at risk of avoidable harm.

There were also examples of risk assessments being completed and no care plan being in place to ensure interventions were identified to reduce the risks. A person had suddenly lost 6Kg in a month; their risk assessment indicated they had been referred to the GP for supplements and the GP was to refer to a dietician. At the time of our inspection eight weeks later there was still not a eating and drinking care plan in place for the person, the person was not prescribed supplements and the frequency of the person being weighed had not been increased and remained at monthly weights.

Falls risk assessments had been completed but clear actions were not in place in response to identified risks to minimise the risk of falls. For example, a person had a falls risk assessment which indicated they were at risk of falling. Actions identified to reduce the risk of falls in the assessment stated only, 'hoisted for transfers' and there was no falls prevention care plan.

When we arrived at the service on the first day of the inspection we saw four people sitting on chairs in the lounges with their moving and handling slings still in place. Staff told us it was difficult to remove them. Slings left in place may increase the risk of the development of pressure ulcers. We saw one person sitting in a wheelchair with the sling in place and complaining of one of the straps irritating their back. A member of

staff said they had told other staff that slings should be removed after assisting people to move but the staff had not followed their advice.

We observed staff followed good practice guidance when using a hoist to support people with transfers. However, we observed at least three staff using poor practice when supporting people to mobilise from a chair to standing. For example staff were seen supporting people under their arms and wheelchair brakes were not always put on when a person was transferring. We also saw that a staff member continued to push a person in a wheelchair without footplates despite our warning that it was a risk. People were placed at risk of avoidable harm.

We saw documentation had been completed relating to accidents and incidents, however, falls had not been analysed since January 2015 to identify patterns and any actions that could be taken to prevent them happening.

There were not complete plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were not in place for all people using the service. Those plans in place were not easily readable in the event of an emergency. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. We saw that fire drills had not been recorded as having taken place for over two years.

We saw that the premises were not always well maintained, safe and secure. We saw some people's bedroom doors were propped open with pieces of equipment such as weighing scales and a vacuum cleaner. Water temperatures were not being recorded for people's bedrooms and a staff member told us that 11 people's bedrooms had water temperatures that were too high. Prompt action had not been taken to address this; however, we were told that immediate action would be taken to address the issue. We also saw that people's bedroom doors closed too fast and put people at risk of injury. We were told that immediate action would be taken to address the issue. Outside clinical waste bins were not secure.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of the inspection we observed staff with the registered manager moving a person correctly. Afterwards we talked with the member of staff again and they said new transfer belts had been purchased to replace others which were difficult to use correctly. The transfer belts that had been used the previous day were unsuitable for use for the people they were used for and this made it more difficult to move the person safely.

During our previous inspection on 14 and 15 April 2015 we identified that staff did not always provide support in a timely manner. At this inspection we found that improvements had not been made and work was required in this area.

People gave mixed feedback on whether there were enough staff to meet their needs. A person said, "There's enough; I don't wait long." Another person said, "Some days yes, some not, because of [staff] phoning in [to cancel shifts]." Another person said, "Sometimes I get furious; sometimes (they are) too busy to bother with things." A visitor said, "Always enough [staff] when I'm here."

Staff told us they felt there were generally enough staff on duty to provide the care people needed. They said there were quite high sickness levels and this caused some issues but they usually found cover when this occurred. However, the registered manager told us that there were some nurse staffing vacancies and as a

result the registered manager was regularly working as the nurse on duty with less time available for managing the service.

We noted there were times when the lounge was left unattended and we heard people calling for staff on behalf of others when they required assistance. There was at least one occasion when there were verbal altercations between people using the service which stopped as soon as a member of staff came into the lounge. People were not being occupied or engaged in any way by staff at the time and if they had been this may have been avoided.

Robust systems were not in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. Staffing levels were calculated according to the amount of people who used the service. However, no documentation was in place to show whether people's differing dependency levels had been considered when calculating staffing levels. Rotas were not fully up to date so we could not see whether sufficient staff were on duty to meet the staffing levels identified by the registered manager.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

During our previous inspection on 14 and 15 April 2015 we identified that there were a number of discrepancies regarding how medicines were managed. At this inspection we found that improvements had not been made and work was required in this area.

People told us that they received their medicines safely and on time. We observed the administration of medicines, saw staff checked the medicines against the medicines administration record (MAR) and explained people's medicines to them when they administered them.

We saw staff mostly stayed with people whilst they took their medicines except on one occasion, when we saw someone's morning medicines were left on a saucer with the person to take whilst they sat at the dining table (there was another person sitting at the table). The registered manager told us they had observed the person at a distance throughout; however, the registered manager was not within eye sight of the person for at least some of the time and the person took some time to take their medicines. The person dropped a tablet and had to search for it in their wheelchair and this was not noticed by the registered manager. This meant the person was not being observed and if another person had tried to remove the medicine, staff would not have been close enough to prevent it.

Medicines were stored within locked trolleys and cupboards. However, the refrigerator used to store medicines was unlocked during the inspection and we also found the room where the fridge was stored was unlocked on one occasion. Daily temperature checks had been completed of the refrigerator and the room used to store medicines and these were within acceptable limits.

Approximately half of the MARs did not have a photograph of the person to aid identification and there was no indication on any of the MARs about the person's preferences for taking their medicines. We found there were at least four gaps in the administration records which meant that there was a risk that people may not have received their medicines on these occasions. Two of these were medicines given for Parkinson's disease which need to be given frequently and regularly throughout the day to ensure they are as effective

as possible.

There were no PRN protocols for medicines which were prescribed to be given only as required. Topical medicines application records had been completed to ensure rotation of the site of application of transdermal patches. People receiving warfarin had had regular blood checks as required and the doses adjusted as directed.

A person was receiving their medicines covertly. A mental capacity assessment and best interest decision had been undertaken in relation to this and this indicated the person's GP had been involved. However, there was no documentary evidence from the GP in relation to this and no evidence the pharmacist had been involved in the decision.

Staff had had initial training and supervision in medicines administration but had not had a refresher in the last two years.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two people had behaviours that might challenge during personal care and had care plans which provided information for staff on the action to take when they tried to strike out at staff. This guidance included, 'securing their arms to prevent injury to [the person] or staff.' This gave staff instructions to use restraint when necessary but staff had not received specific training on safe practices to be used to restrain people. The care plans did not provide sufficient guidance to staff on alternative techniques to gain people's cooperation so that restraint was not necessary.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. A person said, "I feel absolutely safe." However, two people commented that there were raised voices if they did anything wrong. One person said, "Some shouting if I do anything wrong … not very often." Another person said, "I've been shouted at by [people who use the service] and staff, probably because of my own incompetence." Neither person could describe any specific staff member or person who used the service who had shouted at them. We raised these comments with the registered manager so she could monitor this issue. Visitors told us that they felt that their family members were safe.

Staff were aware of the signs of abuse and told us they would report any concerns to the registered manager. They said the registered manager would act on concerns but said if necessary they would escalate to an external agency. When asked about the action they would take if a person using the service was verbally abusive to another, they talked about having a quiet word with the person, separating them and documenting it in their daily record, but they did not identify the need to report this as a potential safeguarding issue.

A safeguarding policy was in place but it did not include the phone number for the local authority. However, this information was available in the registered manager's office.

Information on safeguarding was not displayed in the home to give guidance to people and their relatives if they had concerns about their safety. Staff had attended safeguarding adults training.

People told us the home was clean. Staff told us they had undertaken training in infection prevention and

control and food hygiene. They were aware of the need for the use of personal protective equipment to minimise the risk of infection.

During our inspection we looked at all bedrooms, all toilets and shower rooms and communal areas. All areas were clean. However we observed that staff did not always follow safe infection control practices and wheelchairs were very stained and were not on cleaning schedules to ensure that they were being cleaned.

Inadequate

Is the service effective?

Our findings

During our previous inspection on 14 and 15 April 2015 we identified that formal supervision did not always take place on a regular basis. At this inspection we found that improvements had not been made and work was required in this area.

Most people and visitors told us that staff were sufficiently skilled and experienced to effectively support them. However, one person and one visitor felt that staff knowledge was more mixed.

Staff told us they had completed mandatory training and were up to date with the requirements. However, training records showed that training required updating, only about 50% of staff had received dementia awareness training and no staff had received equality and diversity training. Staff had also not received restraint training. This meant that staff had not received sufficient training to meet people's needs in these areas.

Staff told us they had received moving and handling training within the last two months but we observed poor practice in relation to this, which raised questions about the quality of the training or the monitoring of practice in the service.

Staff told us they had had an appraisal earlier in the year but were vague about whether they had received supervision. One staff member told us they had received supervision once last year. Records showed that staff did not receive regular or frequent supervision. Records showed that staff had last received supervision in July 2015. Supervision and appraisal documentation contained limited detail. The registered manager told us that she observed staff but didn't have the time to record the observations she made. In relation to supervisions and appraisals, the registered manager told us that she was, "Running late." This meant that staff performance was not being assessed to ensure they had the skills to meet people's needs.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection on 14 and 15 April 2015 we identified that some staff were not able to tell us about the Mental Capacity Act 2005 (MCA) or the Deprivation of Liberty Safeguards (DoLS). At this inspection we found that improvements had not been made and work was required in this area.

People's views were mixed on whether staff asked their consent before supporting them. A person said, "It varies really." Another person told us that staff didn't ask permission unless, "It's personal [care]." A visitor said, "[It's a] mixture of asking and telling."

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the MCA.

There was inconsistency in the application of the MCA when people were unable to make some decisions for themselves. In some instances, mental capacity assessments and best interest decisions had been appropriately completed, but in others decisions about people's care had been made without evidence of mental capacity assessments being completed. For example when bed rails were used, consent to their use (or a mental capacity assessment and best interest decision for those who were unable to consent themselves), had not always been completed. Another person had a sensor mat in their room but there was no mention of this in their care plan and no consent for its use.

One person had a mental capacity assessment in relation to their personal care but another person did not. Both presented with behaviours that may challenge during personal care and had care plans which provided information for staff on the action to take when they tried to strike out at staff. This guidance included, 'securing their arms to prevent injury to [the person] or staff.' This gave staff instructions to use restraint when necessary but there had been no DoLS applications to safeguard the people, and staff had not received specific training on safe practices to be used to restrain people.

Although the care plans contained some information for staff to take to gain people's cooperation, this information either didn't include steps such as making an attempt to divert the person's attention or leaving the person for a while and returning later, or when they did, it was in very general terms and did not contain any specific information about things they were interested in or ways they could be diverted. Another person had behaviours that may challenge others; however, their care plans contained no guidance for staff on how to support this person.

No DoLS application had been made for another person living with dementia and presented with challenging behaviour and had a behaviour chart. The behaviour chart indicated that on three consecutive nights the person had been walking around the lounge and telling staff they wanted to go home.

The nurse we talked with was aware of the MCA and DoLS and their implications for people using the service, however, they told us that they had not made any DoLS applications. Care staff had limited knowledge of MCA and DoLS issues.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records contained a form which listed a number of decisions such as the use of photographs, medicines administration, referrals to other professionals, and to seek medical attention when required and the person's agreement to this was recorded. When people could not make the decision for themselves the form had been signed by a close relative to indicate their agreement.

A person using the service had some difficulties in swallowing and had been reviewed by a speech and language therapist who had recommended thickened fluids. The person refused to drink thickened fluids and they were able to understand the risks they were exposing themselves to by drinking fluids which had not been thickened. The person's care records documented their refusal and staff acted in accordance with

their wishes.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and they had been completed appropriately.

People spoke positively about the quality of food available. One person said, "Okay, very good in fact." Another person said, "Very good on the whole." A visitor said, "[My family member]'s put on weight – [they]'re obviously eating well."

Not all people felt that they received sufficient amounts to drink. A person said, "[There]'s often a problem at night, but okay by day." Another person who required full assistance with eating and drinking told us that they did not have sufficient to drink in the late afternoon and evening. They said, "Sometimes yes and sometimes no." They had a catheter and their care plan stated they should have 2000mls of fluid daily. It was 10.10am when we talked with the person and they said they had last had a drink at 5pm the previous day. We checked their fluid chart and the record had last been completed at 3.38pm the previous day. We checked two other days and both recorded the last drink of the day being given at approximately 3.40pm and the person's fluid intake was between 800mls and 1000mls daily. Due to the gaps in these charts and the vulnerability of the person and their specific needs around fluids we made a safeguarding referral to the local authority.

We observed the lunchtime meal in the small lounge. People eating their lunch in this lounge required full assistance from staff. We observed a staff member come into the room with a person's meal. They stood in front of the person and placed a clothes protector over them. They spoke to the person telling them they had their lunch but did not explain what it was or offer any other explanation. They remained standing in front of the person whilst they gave them their meal, the only words being, "Come on open up." This showed a lack of respect for the person. We observed other staff assisting other people in the small lounge shortly afterwards. They sat with the person, explained what was on the plate and offered them encouragement and support.

We also observed the lunchtime meal in the main dining room and lounge. Some people sat in groups at tables, some people sat separately. The tables were not well presented with no table mats, serviettes or condiments. However, the food was well presented with generous portions. People received their meals promptly but people did not always receive adequate and appropriate assistance when they needed it. We saw one staff member assisting two people at the same time and another person was not assisted to eat when they clearly required support.

This person's care plan highlighted their appetite had deteriorated since an admission to hospital and stated they required their food intake to be monitored, to receive fortified food and to be weighed every two weeks. We found they had only been weighed monthly and they had lost 2Kg prior to admission to hospital and since their discharge from hospital ten weeks prior to the inspection they had lost a further 6Kg. They had been of low body weight prior to this and this amount of weight loss was significant. Despite the person having lost 3Kg in three weeks following discharge a referral to the dietician had not been made until a month later. When we talked with the registered manager about this they told us they had not been able to make a referral to the dietician as their access to a dietician had changed following re-structuring. They had spoken with the GP who was going to prescribe nutritional supplements for the person but had not actioned this yet.

We saw that other people's weights were not always being recorded. We also saw that people at risk of choking were not receiving their prescribed thickener. On the day of inspection all people were receiving

their thickener from the same tub. The registered manager explained this was due to some people's prescribed thickeners running out as due to the hot weather people had been drinking more fluids. We were concerned at the lack of a robust system for ensuring that sufficient stocks were available of each person's prescribed thickener.

These were breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they saw the GP when they needed to. They also told us that they saw an optician and the chiropodist. A visitor told us that they had raised a concern about their family member and staff contacted the GP. Staff told us they received good support from people's family doctors. They said they were always willing to visit when people needed a visit and would make referrals to other services such as a speech and language therapist when necessary.

We saw some evidence of the involvement of other professionals such as the dementia outreach team and the family doctor; however, it was not always easy to find documentation in care records to confirm whether professionals had been involved. According to their care record, a person who was being cared for in bed had not been seen by their family doctor since March 2015.

We also saw that some referrals to external professionals were not made in a timely manner and the service did not take steps to ensure people were seen in an appropriate timeframe following referral. When discussed with her, the registered manager did not show any appreciation of the need to ensure people were seen promptly and ensure treatment was initiated.

We saw a person had presented with challenging behaviour and when their care plan had been written in February 2016 it stated the person required referral to the Dementia Outreach Team but we noted the referral had not been made until April 2016.

We looked at the records of a person with diabetes and could not find evidence of a diabetes annual review as required for all people with diabetes. In addition there was no record of them seeing a chiropodist. The registered manager told us they had had a review by the practice nurse for their diabetes and it would be recorded somewhere in their daily record but they could not identify when this had happened. They also said they had seen a chiropodist. Neither of these was documented in their care record in the section for recording contact with other professionals.

We also saw that the person had been sent an appointment for a diabetic retinopathy review but there was a letter indicating they had not attended. The registered manager was unclear as to whether the person had attended the hospital appointment to check them for diabetic retinopathy. Diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the back of the eye (retina). It can cause blindness if left undiagnosed and untreated. When we talked with the person they told us they used to have very good vision in their left eye but it had suddenly deteriorated some time ago. They said they had told staff but no action had been taken. We made a safeguarding referral to the local authority in relation to this person.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adaptations had not been made to the design of the home to support people living with dementia. People's bedrooms were not clearly identified and the displayed date in the lounge (to assist people living with

dementia) was incorrect until late morning on the first day of our inspection. Corridors were poorly lit and handrails were not brightly coloured so that people with visual difficulties could identify them easier. Some bathrooms had symbols on them but not all and there was no directional signage to support people to move independently around the home. There were not sufficient chairs in the home for visitors to use when talking with their family members. The garden area was small and not welcoming. The dining room was small and difficult for staff to support people safely because of the lack of space.

These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

During our previous inspection on 14 and 15 April 2015 we identified that staff did not always promote people's dignity. At this inspection we found that improvements had not been made and work was required in this area.

People felt that their privacy and dignity were respected. A person told us that staff always knocked before they entered their room. Another person felt that their privacy was respected but felt that there were no areas in the home that they could go to, except their bedroom, if they wanted a private conversation. Our observations confirmed this. We also saw that people's care records were not always stored securely.

We saw staff take people to private areas to support them with their personal care and staff knocked on people's doors before entering. However, we saw that people's dignity was not respected at all times. We saw four people sitting on chairs in the lounges with their moving and handling slings in place most of the day. We also saw a staff member scrape food off a person's face with a spoon instead of using a napkin to remove the food. This did not respect their dignity.

The registered manager told us that no staff had been identified as dignity champions. A dignity champion is a person who promotes the importance of people being treated with dignity at all times.

Staff were able to describe the actions they took to preserve people's privacy and dignity. They said they always drew the blinds in people's bedroom when assisting them with personal care and prevented other people coming into the room. They said they would prepare everything first and ensure people were covered as much as possible.

Some people were supported to eat their meals independently through the use of adapted plates; however, this was not always effective. Staff told us they encouraged people to do as much as possible for themselves to maintain their independence.

Staff told us people's relatives and friends were able to visit them without any unnecessary restriction and people we spoke with confirmed this was the case. Visitors told us that they were welcomed by staff when they visited and were offered drinks.

People's views were mixed on whether staff were caring and kind. One person said, "Very kind." Another person said, "Yes, they are alright. Some are alright, some not so good - a bit surly." Another person said, "Kind as far as it goes. Some are kinder than others."

Staff knew the people using the service well and were knowledgeable about their needs and preferences. We saw some staff who had a very good understanding of the people they were caring for and they related to people very well, gaining the cooperation of people who became agitated or confused. We saw some very caring and empathetic interactions and people clearly enjoyed the company of staff. However, we also heard a staff member being quite curt when speaking with a person who used the service.

People's views were mixed on whether they had been involved in making decisions about their care. One person had seen their care plan and been involved in an update. Another person and their visitor had not seen their care records. However, another visitor told us they had been consulted over their family member's needs.

We did not find any evidence in care records of the involvement of people or their relatives in reviews of their care plans. The registered manager told us that they discussed care plans with people who used the service but did not record the discussions. They also told us that no care reviews were taking place where they would meet with people who used the service and their relatives, where appropriate, to obtain their views on the care they were receiving.

One person said, "I've heard of advocacy." A visitor told us they knew how to obtain advocacy support if their family member needed it. Advocacy information was available for people if they required support or advice from an independent person. However we did not see a guide for people who used the service setting out what they should expect when living at the home.

Requires Improvement

Is the service responsive?

Our findings

During our previous inspection on 14 and 15 April 2015 we identified that staff did not always appropriately respond to people's needs and preferences in a timely way. At this inspection we found that improvements had not been made and work was required in this area.

People did not always receive personalised care that was responsive to their needs. We talked with a person who was cared for in bed. We asked them if they had had their breakfast at 10.10am and the person told us they hadn't. They said, "I'm last on her [staff member's] list." We asked them when they liked to have their breakfast and they said that if it was up to them they would have had it much earlier. They said, "I'm an early morning person really." During our inspection, we observed that staff generally responded promptly to people but were not always present when people were requesting support.

People did not raise any concerns regarding the activities that were provided. One person told us that they read books that were brought into them. Some people told us that they went out with their families. Visitors told us that people visited the home to provide exercise activities and were good.

We saw that church representatives visited the home every couple of months and a service took place in the lounge. A person also told us that they had been visited by people from the church.

Activities required improvement. No activities took place in the morning on the first day of the inspection. However, staff appeared less busy in the afternoon and spent time interacting and chatting with people. We saw staff support people to play dominoes, watch a film and one person had their nails painted. The atmosphere was lively and people were engaged in the main lounge. However, we did not see any activities take place in the smaller lounge where people with more complex needs were sitting.

The television was on in the main lounge on the second day of the inspection. We sat next to a person in the lounge who was sitting next to the television but could not see the picture. They told us they had heard the programme before. We asked if they would like to see the picture but they said they weren't interested in it. They said they would rather have the music and singing on. No one in the lounge was watching the television and we did not see staff ask anyone if they wanted the television on. This meant people's preferences were not being asked for or respected.

Activities records for three people whose care we reviewed were limited and no activities were recorded for the two weeks previous to our inspection. There was no displayed activities timetable and no activities coordinator employed by the service.

Care plans did not contain sufficient accurate information to support staff to provide personalised care for people that met their individual needs.

We saw that care plans were in place which provided some information on people's care and support needs. However, there were inconsistencies in the information provided in different care plans for the same person,

and some people did not have care plans for some of their current care requirements.

In addition, some care plans had been originally written two years previously and did not reflect people's current needs. They had been evaluated monthly but it would have been necessary to read two years of monthly reviews to gain an understanding of the person's current support needs.

One person had two care plans for the management of their catheter, in different parts of their care record, which could have created confusion if staff were consulting the record for information on the management of the catheter. Another person had a care plan for eating and drinking which had been produced in March 2014. It instructed staff not to continually prompt the person to eat as this wasn't helpful and did not indicate the person was receiving any nutritional supplements or a fortified diet. However the most recent monthly evaluation for the person said, 'continues to need full assistance with supplemented diet.' It was unclear what these supplements were or how often they were given.

Another person had a diabetes care plan which contained a good level of detail about the actions to take if their blood sugar levels were very low or high. However, it stated the person's blood sugar levels should be checked, 'regularly' and we could not find any evidence of these being recorded. A nurse told us their blood sugar levels had been stable and the GP had told staff they did not need to continue to record the levels. This was not evident from the care plan.

Although care plans were lengthy with considerable standard information, they did not always contain necessary information specific to the individual. A person had no information about the specific continence aids used in their elimination care plan. Another person's safety care plan was a standardised plan with no mention of the use of bed rails but the monthly evaluation stated that bed rails and bumpers were in place. Care plans also contained minimal information about people's preferences in relation to their care and support.

A person's pressure ulcer risk assessment indicated they had a pressure ulcer. There was no record of an initial or on-going wound assessment and no wound care plan or tissue viability care plan. Another person's daily record stated they had a dressing in place but there was no information in the person's care record about the wound, the dressings required or a care plan.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave mixed feedback on whether they knew how to make a complaint. A visitor told us that they would raise concerns with the registered manager and was confident that they would take action. Staff told us if a person wanted to make a complaint or expressed a concern about the service, they would listen to the issue, document it and check with the person they had understood correctly. They would the report it to the nurse in charge or the registered manager. Staff said they did not generally receive feedback on complaints or concerns and felt staff were probably spoken with individually if there was an issue.

We saw that the last complaint received by the service had been responded to appropriately but no formal written response had been sent to the complainant. Guidance on how to make a complaint was displayed in the main reception. However, the complaints procedure did not make any reference to the local authority complaints procedure or the local government ombudsman.

Inadequate

Is the service well-led?

Our findings

During our previous inspection on 14 and 15 April 2015 we identified that the systems in place to monitor the safety and quality of the service were not always effective. At this inspection we found that improvements had not been made and work was required in this area.

Not all people knew whether there were meetings for people who used the service and their families. One person told us they didn't feel involved in the home, "Don't think so as my ideas are not followed."

The last meeting for people who used the service and their relatives had taken place in August 2014. There were no notices displayed in the home to inform people and their relatives of the upcoming date for the next meeting. No surveys were in place to obtain the views of people who used the service on the quality of care provided to them. This meant that people were not actively involved in developing the service.

Two visitors told us they had completed surveys but had not received any feedback. We saw that some comments regarding the lack of chairs and the state of the garden area had not been acted upon. This meant that prompt action had not been taken in response to feedback received by the service.

We saw that the last staff meeting had taken place in April 2015. The staff meeting notes stated, "We need [the registered provider] to order new dining room chairs. We haven't enough and residents are having to sit in wheelchairs in the dining room or in armchairs in the lounge for meals." We saw that there were still insufficient chairs during our inspection. This meant that prompt action had not been taken in response to feedback received by the service.

A registered manager was in post but was not fully available during the inspection as she was working as the nurse in charge at times. She told us that the financial support from the provider was, "Not bad." However, she told us that other support from the provider was limited. We saw that the current CQC rating was not clearly displayed in the home. The registered manager was not aware of the requirements to do so. There was no deputy manager in post and there was no administrative support for the registered manager.

The provider did not have an effective system to regularly assess and monitor the quality of service that people received. We identified a wide range of issues at this inspection which had not been identified and addressed by the provider or registered manager prior to our inspection. These issues placed people at risk of avoidable harm.

Audits were not taking place regularly. The last care records and medication audits had taken place in September 2014. The infection control audit had not identified the issues we found.

The provider's monthly audit was extremely limited and had not identified any of the issues that we found during the inspection.

Areas requiring improvement identified at our previous inspection had not been addressed by the time of

this inspection.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that statutory notifications had not always been sent to the CQC when required. No notifications had been made regarding two safeguarding issues in October and November 2015.

These were breaches of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People's views on the atmosphere of the home were mixed. One person said, "I rather like it here." A visitor said, "It's generally good. I have no reservation." However a person said, "The jury's out. Sometimes it's good; sometimes over the weekend it's crap." A member of staff said, "I like the place. There is a real community feeling here."

People and most visitors felt that they could talk to the registered manager. A visitor told us that they felt that the registered manager would listen. Staff told us the registered manager was available if they wanted to speak with her and they felt able to raise concerns and issues with her. One person said, "I always feel comfortable talking to her." They told us she listened and addressed concerns. Other staff told us of support they had received from the registered manager. However, they said they had not had a staff meeting recently. A staff member told us they would like more frequent staff meetings.

A whistleblowing policy was in place. Staff told us they would be comfortable raising issues using the processes set out in this policy. The provider's values and philosophy of care were displayed in the main reception.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications were not always sent to the CQC as required. Regulation 18 (1) and (2) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive personalised care that was responsive to their needs. Regulation 9 (1) and (3) (a) (b) (c) (d) (e) (f) and (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care was not provided in accordance with the Mental Capacity Act 2005. Regulation 11(1) (2) and (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not managed so that people were protected from avoidable harm. Medicines were not safely managed.

Regulation 12 (1) and (2) (a) (b) (d) (e) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Care or treatment for some people was provided in a way that included acts intended to control or restrain a person that were not necessary to prevent, or were not a proportionate response to, a risk of harm posed to the person or another individual if the person was not subject to control or restraint. Regulation 13 (4) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not always met. Regulation 14 (1) and (4) (a) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Adaptations had not been made to the design of the home to support people living with dementia. Regulation 15(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes did not operate effectively to ensure compliance with the requirements in this Part.

Regulation 17 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed in order to meet the requirements of this Part. Staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1) and (2) (a).