Care Quality Commission

Bupa Care Homes (BNH) Limited

The Arkley Nursing Home

Inspection report

140 Barnet Road, Barnet,
Hertfordshire, EN5 3LJ
Tel: 020 8449 5454

Date of inspection visit: 27 May 2015
Date of publication: 28/07/2015

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?	**Requires improvement**

Overall summary

This inspection took place on 27 May 2015 and was unannounced. When we last visited the home on 7 and 8 January 2015 we found the service was not meeting eight of the regulations, and served two warning notices about care provision and staffing within the home.

The Arkley Nursing Home is a nursing home that is registered to provide accommodation nursing and personal care for up to sixty people. The home did not have a registered manager, but an acting manager was in place, while a new registered manager was being recruited. 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.

Improvements had been made to staffing numbers, medicines management and some aspects of care provision in the home. However since the previous inspection a significant number of staff had left, including management, nursing and care staff. While new staff were being recruited a high level of agency staff were working in the home on a regular basis, and this clearly had an

Summary of findings

impact on the care that people received. The provider was taking steps to minimise the disruption caused with the use of a sole agency to provide all staff cover as far as possible.

There were some improvements in people's involvement in decisions about their care, and record keeping about people's care and the running of the home.

The provider had systems for monitoring the quality of the service and had engaged with people and their relatives to address recent concerns. When people made complaints they were addressed appropriately. However there was still room for improvement in auditing systems to identify areas of concern.

We found improvements in staff training, however there had been a gap in individual supervision support provided following a significant number of staff leaving.

Staff had variable knowledge of people's preferences, likes and dislikes regarding their care and support needs. They knew what to do if people could not make decisions about their care needs, and the procedures for reporting abuse. Safe systems were in place for recruiting staff, and the home was kept clean and hygienic.

People were provided with a choice of food, and were supported to eat when this was needed, some improvements had been made to food provision following a recent survey of food satisfaction. People had a range of activities available to them.

At this inspection there was a breach of regulation in relation to designing care to meet people's preferences and needs, and four recommendations were made regarding medicines, staffing and supervision. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. There were improvements in the number of staff working with people in the home, however a heavy reliance on agency staff presented risks to people who use the service.

Assessments were in place to minimise risks to people, and there were some improvements in the management of medicines in the home.

Staff knew the correct procedures to follow if they suspected that abuse had occurred, and safe recruitment procedures were in place.

The home was clean and hygienic.

Is the service effective?

Requires improvement

The service was not always effective. Improvements had been made to staff training, however individual supervision sessions had not been provided recently to ensure that they had the support and monitoring needed to care for people effectively.

People received a choice of meals and staff supported them to meet their nutritional needs.

People's health care needs were monitored. People were referred to the GP and other health care professionals as required.

Staff understood people's right to make choices about their care and the requirements of the Mental Capacity Act 2005.

Is the service caring?

Requires improvement

The service was not always caring. Although most staff were caring and knowledgeable about the people they supported, the lack of a consistent staff team, impacted on people's experience of continence care, and social support.

There was an improvement in consultation with people and their representatives about their care and support.

Is the service responsive?

Requires improvement

The service was not always responsive. People using the service and their relatives were encouraged to give feedback on the service and use the complaints system.

Care plans were in place outlining people's care and support needs. However people did not always receive person centred care that was designed to meet their needs and preferences.

Summary of findings

Due to a high level of agency staff within the home, staff had variable knowledge about people's support needs, their interests and preferences in order to provide a personalised service. A range of activities were available for people including occasional trips out of the home.

Is the service well-led?

Requires improvement

The service was not always well-led. The home had systems for assessing and monitoring the quality of the service, however they did not always pick up on areas that required improvement. Record keeping had improved within the home.

Actions had been taken to address issues raised at the previous inspection, however there was significant further work required to complete the improvements needed.

The Arkley 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.

At the previous inspection of the home on 7 and 8 January 2015 we found that the home was not meeting a number of legal requirements. We served warning notices relating to care and welfare of people using the service, and staffing numbers, and found deficiencies relating to the management of medicines, respecting and involving people, supporting workers, records, managing complaints and quality assurance. Prior to the current inspection we reviewed the information we had about the service. This included information sent to us by the provider, such as action plans for rectifying the breaches identified at the last visit and notifications of incidents that had occurred. We also spoke with three health and social care professionals about their views of the quality of care in the home.

This inspection took place on 27 May 2015 and was unannounced. The inspection was carried out by an inspector, a pharmacist inspector, a professional advisor who was a nurse with knowledge of older people's needs, 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.

During the inspection we looked at the care plans, risk assessments, and daily records relating to ten of the 35 people who were living at The Arkley Nursing Home. We also spoke with nine people using the service, six relatives of people using the service, the acting manager, the quality manager, three nurses, five care staff, including two night staff and two agency workers, and five other staff on duty. We looked at six staff files, the last month and future month of staff duty rosters, accident and incident records, selected policies and procedures and 15 medicines administration record sheets.

Following the inspection we spoke with three relatives and two health care professionals of people using the service, who visited the home regularly.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe at the home, although two people had some concerns about the behaviour of other people living there. When asked if they felt safe, they told us, "I feel safe," "I think so," and "More or less." One person said they felt better since asking for their door to be closed at night. Another person said they found it difficult having so many different staff supporting them, they said, "You get a bit nervous because it's not always the same person so you wake up and think 'who's that?'"

At our previous two inspections in May 2014 and January 2015 people were not protected from receiving unsafe or inappropriate care or treatment, and a warning notice was served due to this continuing breach following our last inspection. An action plan was provided by the acting manager and during our current visit, we found evidence that actions detailed in this plan had been undertaken.

A record was available of each person's ability to use the call bell system, including a new pre-admission and reassessment tool to monitor this. In May 2015 people at the home were surveyed about their experience of call bell answering, indicating largely positive feedback about improvements in answering times. Records were being maintained by the acting manager or a senior person conducting a daily walk around the home to ensure call bells were in people's reach.

Call bell response times were being collated for each day, with all calls answered in six minutes or above highlighted.

There were daily checks of medicines administration records in place, and nursing staff competencies at administering medicines had been assessed. At the time of the inspection no one in the home required a syringe driver for provision of medicines, however training had been provided in this area, and this was a requirement for agency nursing staff working at the home. A daily staff handover record had been put in place to ensure that important information was passed on. New systems were in place to ensure that actions required after health care appointments were carried out and weekly clinical risk meetings were held. Staff we spoke with had knowledge of general first aid and emergency provisions within the home such as the presence of resuscitation equipment and glucogel (used to treat low blood sugar levels).

People who used the service and their relatives told us that they could raise concerns with staff or the acting manager. Staff we spoke with understood the service's policy regarding how they should respond to safeguarding concerns. They knew who they should report to if they had concerns that somebody was being abused. They had received training in safeguarding adults and we saw evidence that incidents had been reported appropriately. Risk assessments were in place to ensure that risks to people were addressed. There were detailed risk assessments for all identified risks including falls, pressure ulcers and behaviour that challenged the home. These were reviewed monthly and any changes to the level of risk were recorded with actions identified to decrease the risk.

At the previous two inspections in January 2015 and May 2014 we found that there were not always sufficient numbers of suitably qualified, skilled and experienced staff employed at the home. A warning notice was served due to this continuing breach following our last inspection and an action plan was provided by the acting manager. During our current visit, we found evidence that actions detailed in this plan had been undertaken.

Before the inspection we were contacted by three relatives of people living at the home and a person living at the home with concerns about the care provision following a significant number of staff leaving including the manager and deputy manager. We contacted the provider, who told us of the plans in place to manage the situation while new staff were recruited. It was clear that this was a very difficult time for people living in the home, their relatives, and existing staff working at the home. Whilst recruitment was underway there were still a large number of agency staff working in the home at the time of our inspection. Following concerns raised, the provider undertook to use staff from one particular agency to cover as many shifts as possible, and only use other agencies for back up. People told us that they were generally happier with the staff provided by this agency, with the same staff working regularly which made a big difference to the continuity of care in the home.

During our visit, people told us that there had been an improvement in the time taken to respond to call bells, and this was not a particular concern at that time. This included

Requires improvement

Is the service safe?

people who had contacted us to express concerns about the call bell answering before the inspection visit when this had been a significant issue. We observed call bells being answered quickly during our visit.

However one relative told us, "They don't have time to care properly, there aren't enough of them [staff]. Sometimes they snap a bit because they're so busy." One person told us that staffing at the home was improving, but that at weekends and in the evenings there were not enough care workers, particularly at meal times when kitchen staff were not available to help serve people. Another person said, "You have to wait [for care] sometimes. Sometimes, I'd like to get dressed and have a shower and they're a bit long in coming."

At the time of the inspection there were 35 people living in the home (including one person who was in hospital). There were no people being provided with end of life care at the time of the visit. At the last inspection, the presence of agency nurses only, without a nurse employed by the provider, was a clear factor in concerns about the quality of care provided to people receiving end of life care. Due to the loss of a significant number of staff including nursing staff, there were frequent occasions when the home was covered by agency nursing staff only. The acting manager advised that a significant recruitment drive was underway, although they noted on-going difficulties they were experiencing in the recruitment of nurses to work in the home. They advised that they were looking at reviewing pay and other staff benefits to address these issues.

We requested data since the previous inspection of staffing hours per resident each week in the home, as recorded by the provider, and found that there had been a significant increase in staffing numbers per person (from 37.5 to 50.5 hours per week). However it should be noted that the home had made the decision not to take on any new residents during this time period. The staffing in the home on the day of the inspection matched the rota, which indicated that there were usually three nurses on shift in the morning, and two in the afternoon and at night, with seven or eight health care assistants during the day and four at night. The acting manager noted that in addition to this, extra time was allocated on the rotas for staff to undertake record keeping and other tasks.

In April 2015 the acting manager had undertaken a review of staffing levels in the home, using an approved tool and also the provider's own dependency banding. This indicating that staffing provided was exceeding the needs calculated.

All but one staff member spoken with said they thought there were enough staff to meet everyone's full care needs, although they described difficulties working with such a significant number or agency staff. Due to the layout of the building, we found that staff were not always easily visible, and this was also mentioned by relatives and health and social care professionals who visited the home. Health and social care professionals noted that the lack of continuity of employed nursing staff was still having an impact on communication within the home and affecting the care and treatment provided to people.

We were concerned to find that logs of call bell waiting times indicated that there had been waiting times of over 30 minutes on approximately four occasions on 11, 12 and 26 May (including waits of 86, 61, and 57 minutes), three occasions on 22 May (including a wait of 107 minutes), and two occasions on 8, 13, 24 and 25 May. This did not tally with the feedback we received from people living in the home and their relatives about improvements in this area. The acting manager suggested that this information might not be accurate, due to staff forgetting to cancel call bells after they had answered them, or a fault in the system. They conducted their own survey of call bell answering which did not indicate that long call bell waits were a significant issue in May 2015.

Safe recruitment procedures were in place to ensure staff were suitable to work with people. Staff had undergone the required checks before starting to work at the service. The three new staff files we looked at contained disclosure and barring checks, two references and confirmation of the staff member's identity. They also included interview records and checks on professional qualifications.

At the previous inspection we found that medicines were not managed safely. An action plan was produced by the provider and we found that improvements had been made. People told us that they were able to get pain relieving medicines when needed. People's medicines were stored safely and under suitable storage conditions. We found the temperatures of the areas where medicines were stored were monitored and recorded regularly and were within acceptable limits. But we found the service did not have a

Requires improvement

Is the service safe?

suitable cupboard in one area, for the storage of controlled drugs. These are medicines which are subject to special storage and recording arrangements due to their liability for misuse. The manager told us that a new cupboard was on order and we were assured that the current temporary arrangements were being managed safely.

We found that there were suitable arrangements in place to record when medicines were received into the service, when they were given to people and when they were disposed of. We looked at the medicine records for 15 of the 34 people using the service on the day of our inspection. In general, we found that the medicines administration records had been completed to show people had been given their medicines as prescribed and the records were consistent with the stock of medicines remaining. We found that when people received their medicine in the form of a skin patch, the record made did not contain sufficient detail of the site of application to prevent damage to a person's skin if the same site was used repeatedly. We also found that one person had not been given their medicine the previous evening but no record had been made, and staff could not tell us of the reason why the medicine was omitted. We brought this to the attention of the manager who told us they would investigate this as a matter of urgency.

Some people had their medicines crushed and given to them through a tube directly into the stomach as they had difficulty swallowing. We found there was inconsistent guidance for staff about how this was to be done safely.

We found protocols were in place to guide staff on how to administer medicines prescribed on a "when required" basis, for example for pain relief, so that people were given the medicines consistently and correctly. However, we found that this guidance was not always consistent with the person's care plan.

We observed medicines being given to some people during lunch time and saw that this was done with regard to people's dignity and personal choice. We saw that the nurse stayed with the person while they took their medicines and supported them to do so when necessary. However, we found that there was no information in the care plans to indicate how people preferred to take their medicines, so we couldn't be sure that they would consistently get the support they needed.

The manager and staff told us, and training records confirmed, that staff authorised to handle medicines had been assessed that they were competent to handle medicines.

The manager told us, and records confirmed, that auditing of the medicines management processes had taken place. Nursing staff also completed a check list at the end of each medicine round to ensure that the records are completed correctly. We saw records of the checklists and audits but we noted that some of the issues we found in the records had been picked up by these audits but others had not. We were therefore not fully assured that processes were in place to identify and resolve medication errors promptly.

People told us that the service was clean. One relative said "The cleanliness is fine." Overall the home looked bright and clean. Cleaning charts were kept which showed that there were clear systems in place to ensure that all areas were cleaned regularly, and infection control audits were carried out regularly. However throughout the day of our visit there was a strong unpleasant odour near the entrance to the Garden Suite corridor (rooms 28-36). The communal bathrooms on this floor were also less clean, and these rooms appeared in need of some redecoration.

We recommend that the service consider improving the care plans to contain details of how people like to take their medicines and how they are administered by special techniques.

We recommend that the service consider improving the records made when medicines are administered in the form of a skin patch and that audits and checks of medication records are more effective.

Requires improvement

Is the service effective?

Our findings

People spoke positively about the majority of staff that support them. They told us, "There is a good standby agency and they are being very helpful," "They've got very good carers, they're all very good," and "I like my own space, and they have respected this." However one person felt the staff were, "not qualified for people like me," and did not support them to be independent, noting, "They don't like me doing things on my own, they panic."

At the previous inspection we found that staff had not received all the necessary training and support they required in their work with people. At that time we found that staff were not always receiving supervision at the frequency stipulated by the provider of six times a year, there were significant gaps in staff training, and there were no clear induction procedures for agency workers covering shifts at the home. The provider produced an action plan and we found that most of these actions had been put in place. However since the previous inspection a significant number of staff had left employment at the home, including senior staff and management who had been providing supervision. A large number of agency staff were used at the home on an on-going basis, and the management had implemented an induction record for agency staff to complete on their first shift at the home.

People living at the home and their relatives had contacted us prior to the inspection with concerns about the large number of agency staff in use, and the impact this had on continuity of care. At the time of the inspection, they told us that following a difficult period, the provider had arranged for one agency to provide all staff cover to the home, using two other agencies only in the event that this agency was unable to provide cover. People told us, "We are getting better agency now," "They are much more suitable," and "A big improvement." However they did note that there were still some issues with communication in the home.

There had been an improvement in staff training. The provider had implemented improved recording of induction training for new staff, and provision of training to the staff team. Training had been provided in a number of identified areas including dementia care, safeguarding, diabetes, food hygiene, nutrition, pressure ulcer care, managing behaviour that challenges, mental capacity and other mandatory training. Competencies were in place for nursing staff to be assessed for end of life pain relief using a syringe driver. However 17 staff had still not completed dementia training, and end of life care training was still required for nursing staff.

The acting manager advised that recruitment was underway to fill the vacancies at the home including the posts of manager, deputy manager, nurses and health care assistants. We found records of face to face induction training and at least three shadow shifts for new staff who had commenced work at the home. However supervision was not yet in place for new staff at the home. The acting manager had commenced supervision sessions with heads of department including catering, housekeeping and nursing staff, with the aim that they would then provide supervision to their teams. There had been a meeting for the entire staff team on 24 April 2015, and records were kept of all daily meetings between heads of departments within the home.

Staff told us that they felt supported by the acting manager, who represented a calming influence on the home, although it had been a very difficult time to be working at the home with so many staff leaving. One new member of staff who had not worked in care previously, noted that they did not feel fully confident after five days of shadowing other workers, and would have preferred longer. However they noted that the training provided before they commenced work had been very helpful, particularly experiencing what it was like to be lifted in a hoist. They noted however that despite being relatively new, there were an occasion when they were the only permanent staff member working with all other staff members on duty being agency workers.

Agency staff confirmed that they had received induction training, and that it was "a nice place to work," and the manager was "supportive." However one agency workers contacted us after the inspection to express concerns about the quality of induction training provided to them. The acting manager advised that all nurses provided by the agency were required to have had training in setting up syringe drivers, tracheostomy management, dementia training and PEG feeding (feeding by tube directly to the stomach).

People said they were able to make choices about their care. However the acting manager was aware that Deprivation of Liberty Safeguards (DoLS) were required for some people living at the home (who were unable to go

Is the service effective?

out unsupervised, and did not have capacity to consent to this arrangement). We raised the case of one person whose needs had changed, and told us that they did not wish to be living there. The manager advised that this person's needs would be reviewed and that an urgent DoLS application would be made if this was required.

We found that assessments were in place to comply with the Mental Capacity Act 2005 (MCA) regarding people's capacity to make decisions and consent to their care and treatment. Care records contained best interests decisions and made it clear as to whether people had capacity to make decisions. Staff had received training on the MCA. Staff interviewed were aware of the need to ensure that those with capacity were supported to make their own decisions and choices. This was achieved by the staff asking permission to carry out each task before commencing it and gaining their consent.

People had variable opinions about the quality of food served in the home. Approximately half of the people we spoke with were happy with the food, and felt that the menus were improving and that kitchen staff were trying hard. Comments included, "I'm quite satisfied, you have variety," and, "The food is very good." Three people told us that they were very unhappy with the food served. One of them said that food had previously been fresh and purchased locally, but not it all came from a central provider, with limited choices and poorer quality, adding, "I'd like them to have to sample it.. the vegetables are cooked to death." Other comments included, "I'm not very keen on the food. It's the way it's cooked I think," and "It's not nice, the way it's cooked and there's not much choice." One person noted, "The cook's good but he can only cook what he's given."

We observed that breakfast was served to the vast majority of people in their own rooms, and staff said that this was most people's preference. Approximately nine people ate lunch in the main dining room area, and one person ate alone in the upstairs dining room, while others ate in their rooms. There were menus on the tables, and everyone was offered juice or water with the meal. One person needed assistance, and was supported to eat by a care worker in an attentive and unrushed manner. Another person was asked politely if they would like assistance with cutting up their food. On the day of the inspection food was served promptly, but one person said that people were usually called to the dining room far too early, giving the example that, "We're called for tea at 4.40 and left sitting till 5.30."

People's nutritional needs were assessed and when they had particular preferences regarding their diet these were recorded in their care plan. The chef was aware of the dietary needs of people who had diabetes or who were on particular diets. More choices had been added to the menus. People chose their meals the day before. Snacks were also available throughout the day.

Food and fluid charts were in place for people on a reduced dietary intake, or where concerns about their nutrition were identified, to monitor the amount of food or drink they consumed. Where necessary we saw that people had been referred to the dietician or speech and language therapist if they were having difficulties swallowing. Nutrition and hydration was monitored by monthly weight records, reporting by care assistants, fluid balance charts and food diaries. Appropriate protocols were in place for people who received food enterally (directly by tube).

A food survey had been conducted for the home in May 2015, indicating that 39.6 per cent of people thought the food was good or excellent, 31.9 per cent thought the food was acceptable, and 28.5 per cent rated the food as poor or unacceptable (or did not answer). Improvements suggested as a result of this survey included smaller portion sizes, more varied fruit and salad options, and more vegetarian options as a main choice. These suggestions were in the process of being implemented at the time of the inspection.

People said that they had access to health care professionals. They confirmed that the doctor visited the service at least once a week, and they could see a dentist, optician and chiropodist when needed. The service made arrangements for people to either attend outside health care appointments or for specialist support to visit them. One person mentioned that they would like to have more physiotherapy.

We observed that instructions from health care professionals such as a tissue viability nurse (regarding pressure ulcer care) were followed by staff at the home.

Requires improvement

Is the service effective?

Clear records were maintained of the outcome of health care professional visits. Health care audits were in place for people in the home including nutrition reviews, pressure ulcer logs and annual health checks.

We recommend that while the home is relying on a large number of agency staff, that those working regularly are included in training and supervision arrangements.

Requires improvement

Is the service caring?

Our findings

Most people felt well cared for, and that they were treated with dignity and respect. Negative comments were mostly about the large number of agency staff employed at the home and the high turnover in care workers. People told us, "They are very kind," "You're looked after, the care staff are good," "It's a very nice place to be in," "The girls, generally speaking, are very nice," and, "They're trying hard to get the staff, and the way of working is better." However one person described the care as "poor" and then added, "when they come." Another person told us, "Many of the staff are very good, many are very bad and there's nothing in the middle."

Three people said that they had to wait to be taken to the toilet. We were particularly concerned to learn of at least three incidences when people had been told to use their incontinence pads, because staff were too busy to assist them to the toilet. However these appeared to have happened some months previously. We notified the acting manager of our concerns and they sent us the results of a continence needs survey conducted by the provider's Quality Manager on 1 June 2015. Overall this indicated that people were satisfied with the continence care provided, and where issues were raised these were discussed with people to ensure that their preferences were respected.

Three relatives expressed concerns about the care provided. One noted that older people, "need someone to spend a bit of time with them and it doesn't happen." Another relative said, "They don't treat them with respect or dignity, they think they're just old people who need stuff. I don't like it." A third relative was concerned about the changes in staff saying, "All the staff left and now it's just agency. It's not good. There are different people all the time."

At the previous inspection we found that people were not always treated with dignity and given choices about their care. The provider produced an action plan including the provision of pagers for all care and nursing staff, nurses to support care staff with care, monitoring of call bell response times, and nurses to be available at meal times to supervise and assist. In addition care plans were being amended to include people's preferences and people's signatures to evidence their consultation. We found that some people were having the choice to have a bath now, rather than only having showers offered to them, and there were more choices of times for getting up.

However people described difficulties with having so many agency staff. One person said, "Too often you have to tell them exactly what to do, and they don't know anything about the residents' likes and dislikes.. some come in at 6 or 7 [in the evening] and ask if you want to brush your teeth ready for bed. I don't go to bed then! That drives me potty. I just say no." Similarly another person told us that they could not be "bothered to explain to each one how I stand up, how I get washed and everything." One relative felt that agency staff were being put under too much pressure and not given time or sufficient training to settle in.

Most people felt that the situation was improving with the use of one primary agency to supply the majority of staff. One person said of the previous agency staff, "Ooh they were horrible, quite nasty, they didn't wash you properly." However they felt the situation was improving, noting, "It's getting better now, you get to know them." The problem of staff not knowing people and their needs was illustrated when a nurse was asked if there was anyone who would find being approached by an inspector distressing, and replied, "I'm not sure, I'm agency."

Rooms had been personalised making each individual room homely. We found that staff were polite in their interactions with people although these were almost exclusively task-based. But we did see one care worker showing affection and warmth and joking with a seriously disabled person, with communication difficulties, who appeared to enjoy the attention. Staff told us they always knocked on people's doors and waited for an answer before entering, and always explained what they were going to do first, and observations confirmed this.

People had mixed views about whether they were involved in making decisions about their care. New care records included a place for people or their representatives to sign to evidence consultation, but not all had been completed.

Staff understood people's needs with regards to their disabilities, race, sexual orientation and gender. Care records showed that staff supported people to practice their religion and attend community groups that reflected their cultural backgrounds. A religious service was available to people on a regular basis.

Requires improvement

Is the service responsive?

Our findings

We received mixed feedback about the responsiveness of staff to people's needs within the home, indicating that there were sometimes delays in meeting people's needs. One person told us, "I've no complaints," and a relative said that a staff member "lets us know if there's anything we need to know." However other people's feedback and our own observations indicated that this was an area of concern.

On the day of our visit, one person's power wheelchair had not been charged. They told us that they were extremely uncomfortable in the wheelchair in which they were sat. This was a standard wheelchair with no head or neck rest, whilst their personal power chair with neck and head support was being charged. There was a large notice by the person's bed with a clear handwritten instruction saying, "Please can you charge X's chair at night." However this had not been done, and this person's relatives later confirmed that this failure to charge the chair had happened before on more than one occasion. They told us, "They either forget to charge it or they're not told." We also observed that a health care assistant was not very responsive in addressing the discomfort of this person during our inspection visit, as they requested support for their head. The staff member said that they would have to wait for the power wheelchair. Only when a member of the inspection team asked whether a temporary solution could be found, was an effort made to make this person more comfortable with a pillow.

Another person told us that they were very uncomfortable sitting in the dining chairs, and therefore ate alone in their room, as they needed a well-padded chair with lots of pillows. This meant they spent most of the day on their own. Other options had not been considered to enable this person to make them comfortable in a suitable chair in the dining room or lounge.

Three relatives told us that when they raised issues with the staff at the home, they often did not receive any feedback. One relative was concerned about repeated issues with their family member's continence care, head positioning, and tracheostomy care which they said had led to repeated hospital admissions. They told us that concerns they raised were not followed up by staff in the home. We encouraged this person to make a formal complaint to the home so that their concerns could be addressed.

The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we found that there were some gaps in people's care records. The provider produced an action plan, including the transfer of care records to a new format, regular care plan audits, and where possible an additional nurse would be scheduled on shift with time available to update records. There were also spot checks of food, fluid, turning and other care charts.

We found that it was easier to access important information from the new format of care records that had been put in place. The provider was in the process of transferring all care records to the new format with 86 per cent transferred on 18 May 2015. Regular care plan audits were being undertaken to ensure that records were completed appropriately and reviewed at least monthly. However we did find some gaps in people's daily records and some fluid records indicating that two people were drinking only 200-700ml of fluid on many days. We raised this with the acting manager, who advised that staff were aware and were consulting with health professionals on how to address them. However this action had not been recorded in their care records.

The home offered a programme of activities including regular monthly outings, which were popular. Outside entertainers come in on a regular basis and an activities schedule was posted on the wall by the main lounge. An activity coordinator visited each person in the morning to chat to them and get their menu choice for the next day. This staff member clearly knew people very well and had warm and friendly conversations with them. An afternoon activity session in the main lounge was good humoured and energetic, involving memory games, a quiz and some arts and craft work for one person. However only four people took part.

People told us, "I like the singing," and "If there's anything going on, I'll join in." One person said, "There used to be more activity, but now there's not so many people here and sometimes it's a bit boring." Another person was unhappy with the choice of activities available to them apart from the outings. Recent activities recorded included, planting sunflowers, bingo, bread making, back exercises, quizzes,

Requires improvement

Is the service responsive?

reminiscence, flower arranging, and sensory cushion sewing. There had been recent trips to Duxford Imperial War Museum, Kew Gardens, and St Albans, and a trip was planned to Whipsnade in the next month.

At the previous inspection we found that people did not always have their concerns addressed, and there were some gaps in the records of complaints where people were awaiting responses to issues raised. An action plan was provided, and we found that there was a clear record in place of all complaints received since the last inspection, including details of action taken to address them. Issues raised included staff conduct, food consistency, and record keeping.

There was a notice displayed in the home explaining how to make a complaint, and recent resident and relatives meetings had been held at which people had an opportunity to raise their individual and group concerns.

Requires improvement

Is the service well-led?

Our findings

People and their relatives told us about the difficulties the home had been through in the past few months, with many staff leaving and a high reliance on agency staff. Most people thought that things were beginning to improve. As one person noted, "It's pretty good but there's been a terrible lot of carers." One person spoke of a previous manager who used to come in and see everyone in the morning and ask if they needed anything, "but now, nobody comes round like that," and a relative said that they thought the home had "gone downhill."

At the previous inspection people and their relatives did not feel consulted and involved in decisions about the care and treatment being provided at the home, and there were insufficiently rigorous quality assurance procedures in place. The provider produced an action plan to address the breaches found. However the previous acting manager and deputy manager had left employment at the home before the current inspection visit.

At this inspection we found a number of improvements in the management of the service however the running of the service did not always appear to be focussed on the individual needs of people. One person mentioned a number of different issues on which they had to "speak out" in order to have their preferences respected, and said that they had not realised on first moving into the home that they could do so. For example they told us, "I asked for salads which I didn't know I could ask for." They had also decided not to go to the dining room when called because it was always too early, but to go when the meal was actually served. Whilst feeling that their needs were largely met, they observed that, "They try to make you fit in with them, not the other way around." Similar comments were made by other people living at the home and their relatives.

A new acting manager had commenced work at the home on 28 April 2015, approximately one month before our inspection visit. His role was area clinical project manager, and his remit was to manage the service over the next six months whilst recruiting a registered manager and deputy manager to take on this role. He acknowledged that there was a need for significant further work to complete the improvements needed at the home. We received positive feedback about the impact of the manager despite his short time in post. People living at the home and their relatives felt that he listened to them, and staff told us, "The manager is calm, settling, and very supportive," and "A lot of good staff left, the manager listened to us and addressed the issues."

Following a number of concerns about staff leaving, and agency staff usage, the provider had written to people and their relatives on 21 April 2015 acknowledging that this was an anxious time, clarifying the situation and inviting people to a meeting to discuss their concerns. Resident and family meetings were held in the home on 24 April, 7 May, and 21 May 2015. Solutions discussed included the use of one agency only to meet the majority of staffing needs, recruitment, training and analysis of staff leaving exit interviews. Common trends identified included a lack of sufficient orientation and induction, high use of agency staff, the requirement for staff to work between floors in the home, staff pay rates and staffing ratios. These issues were discussed at the meetings in addition to the most recent CQC report, the appointment of a resident/relative representative on the home's quality team, people's individual concerns, food choices, and producing newsletters for the home. Following the last meeting it was agreed that these meetings would be scheduled monthly.

A newsletter was circulated on 30 April 2015 introducing the new manager, new staff, new care planning records, and staff handover documents to be maintained at the home. In response to feedback from the resident/relatives meetings, a relative quality representative was chosen, a food survey was conducted on 8 May 2015 and more food choices were added to the menu.

A general staff meeting was held in April, and a heads of department meeting was held in May 2015. Weekly clinical review meetings were in place, and records indicated that they recently covered preadmission information, incidents, swallowing difficulties, behaviour that challenged, and monitoring data about people's health including falls, nutrition, and skin integrity.

The manager told us that he or a senior person conducted a walk around the home to check on standards at least daily, and these were now being documented. We also met with the quality manager for the home, who visited the home regularly. She took a clinical lead role supporting nurses in the home, monitoring clinical procedures and competencies, delivery of care, and record keeping. Her

Requires improvement

Is the service well-led?

visits were unannounced and her role included conducting random checks on care plans, observing mealtimes, supporting staff to develop leaderships skills, and attending clinical risk review meetings.

Recent quality monitoring visits had been undertaken on 29 and 30 April, and 18 and 19 May 2015. Areas covered included communication, care documentation, staffing, medicines, maintenance, safety procedures, and the environment. The results of a food survey and a call bell survey were recorded in May. The call bell survey indicated people's perceptions of waiting times and ability to use the system, indicating that there were still issues regarding waiting times, and responses. However we were concerned to find that although the provider was collecting information about call bell answering times on a daily basis, the causes of long waiting times identified had not been investigated.

A medicines audit was undertaken on 21 May 2015 and a medicines service improvement plan was produced for the service following this audit. However we were concerned to find that it did not pick up on some gaps, and inconsistencies that we found during our inspection, and this information was passed on to the acting manager.

At the previous inspection we found a number of gaps in records maintained at the home including significant gaps in the staffing rotas, and no recent fire risk assessment or record of clinical meetings held at the home. These issues had been addressed by the time of this inspection, and we found that accurate staffing rotas were being maintained, a current fire risk assessment was available, and records were kept of clinical meetings held in the home.

Incident and accident records were recorded with details about any action taken and learning for the service. Incidents and accidents were reviewed by the acting manager and action was taken to make sure that any risks identified were addressed.

We recommend that the service ensures that there is consistent permanent staffing within the home prior to taking on new admissions and particularly people with complex end of life care needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person did not ensure that service users' care and treatment was designed with a view to achieving their preferences and met their needs. Regulation 9(3)(b)