Bupa Care Homes (CFChomes) Limited

Wilmington Manor Care Home

Inspection report

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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

Summary of findings

Overall summary

This inspection took place on 14 November 2016 and was unannounced. Wilmington Manor Care Home provides nursing care and accommodation for up to 50 older people. There were 42 people living at the home at the time of this inspection. When we last inspected the service on 12 May 2014 the provider was meeting the required standards. At this inspection we found that the provider was not meeting the required standards.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Risks to people's safety were not always safely managed by staff. People who were at risk of malnutrition, falls or developing pressure ulcers, did not have appropriate assessments carried out consistently. Risk assessments were not always developed with detailed management plans to offer guidance for staff in what steps were needed to mitigate the risks and keep people safe.

There were insufficient numbers of suitable staff available and deployed to meet people's needs consistently across all areas of the home. Safe and effective recruitment practices were followed to make sure that staff were of good character and had the experience and qualifications necessary for the roles they performed.

Incidents or accidents were not always reported to the registered manager for review, subsequently not all were reported to the local safeguarding authority or Care Quality Commission (CQC). Not all the staff spoken with were knowledgeable about the risks of potential abuse or knew how to report concerns internally and externally to local safeguarding authorities.

People had their medicines administered by trained staff; however they did not always receive their medicines as intended by the prescriber. Staff did not always follow GP`s instructions when administering people`s medicines.

Not all the people who had a diagnosis of dementia or had a confused state of mind had mental capacity assessments in place to establish if they had capacity to understand and take informed decisions regarding the care and support they received from staff. Best interest processes were not always followed to ensure the care and support people received was in their best interest.

People told us they were not always involved in decisions about their care, they could not recall having been involved. Their consent was not always accurately reflected in their individual plans of care. Care plans were not personalised to reflect people`s likes, dislikes and preferences about the care they received. They had not identified and detailed all the care needs people had and did not offer sufficient guidance for staff to

understand and deliver care and support in a personalised way. People`s care plans were not always reflective of their current needs.

People who lived at the home had mixed views about the skills and abilities of the care staff. Staff received induction training when they started working at the home. However the provider failed to ensure that staff had yearly refresher training in key areas such as safeguarding, food hygiene, manual handling and fire training. Staff told us they had regular supervisions and felt supported by the home management team.

The quality assurance systems were not effective. The regular audits carried out by the registered manager and the provider had not identified all the issues and concerns we identified at this inspection. Care records were not up to date and were not always reflective of people`s care needs.

People were cared for in a kind and compassionate way by staff. However the care and support provided for people nearing the end of their life did not always promote their dignity and privacy.

At this inspection we found the service to be in breach of Regulations 12, 13, 11, 9, 10, 18 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's health and well-being were not always identified or recorded and plans were not developed to give guidance to staff in managing risks.

People did not always receive their medicines as intended by the prescriber.

There were not enough numbers of staff available and deployed to meet people's needs at all times.

Staff not always recognised or knew how to respond to the risks of abuse and how to report to local safeguarding authorities.

Safe recruitment practices were followed to ensure staff were of good character and suitably qualified for their role.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act (MCA) were not always followed to ensure people received care which was in their best interest.

People had access to health and social care professionals however staff were not always prompt in requesting professionals input when peoples` needs changed.

People were supported to eat a healthy balanced diet.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they were not involved in their care and this was not always delivered as they liked it.

People nearing the end of their life were not always cared for in a way to promote their dignity.

People who lived at the home told us staff were respectful, kind and caring.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care from staff.

People were not always provided with opportunities to pursue social interests or take part in meaningful activities relevant to their needs.

Complaints were not always recorded by staff or handed over to the registered manager for investigation. Lessons to be learned were not always shared with staff to help improve the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The quality assurance and governance systems used by the registered manager and the provider were not always effective in identifying areas for improvement.

Records relating to people`s care were not always up to date and did not provide staff with sufficient guidance in how to meet people`s needs safely and effectively.

Staff felt supported by the registered manager and the provider. They were clear about their roles and responsibilities.

Wilmington Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider met 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 under the Care Act 2014.

The inspection was carried out on 14 November 2016 and was unannounced. The inspection team consisted of two inspectors, an expert by experience and a specialist adviser. An expert by experience is someone with personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with 11 people who lived at the home, five relatives and six care staff. We also spoke with the registered manager, regional manager, home improvement manager, deputy manager, two nurses and the chef.

We viewed care plans relating to eight people who lived at the home. We also looked at other documents central to people's health and well-being, recruitment records, staff training records, medication records and quality audits. We carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in Wilmington Manor. One person said, "I feel safe when I get up at night to go to the toilet." Another person told us, "I chose to come here so I could be safe and I made the right choice. I know they are short staffed sometimes but I still feel safe."

We found that where risks to people`s well-being were identified there were risk assessments in place to give guidance to staff in how to mitigate these risks. However staff we spoke with were not always knowledgeable about these measures and did not always followed them. For example one person who had several falls was seen by their GP who suggested to staff the use of a sensor alarm to alert staff when the person wanted to come out of bed and needed help. We observed this person in their bedroom and there was no sensor alarm. We asked a staff member about this and they told us, "I know [person] used to have a sensor alarm, but I didn't see it today. I don't know where it is." We spoke with the deputy manager who told us, "[Person] should have the alarm plugged in, staff should know this." The deputy manager then found the alarm in the person`s bedroom and plugged it in.

One person told us they didn't feel that the environment was always made safe for people who walked around the home because staff left equipment used to assist people with their mobility in the corridors. They told us, "You [inspector] see, they [staff] leave the hoist in the middle of the corridors and people cannot get past. I don't think that is safe for people. They may have falls." We observed throughout the inspection that staff were leaving the hoists in the corridors which was a potential trip hazard for people.

We observed a person who had bruises on their arms. Staff told us they were at high risk of falls and they were prone to injuries when they were walking around because they bumped into things. We found this person had three falls in October 2016 which were recorded on accident forms. When we checked this person`s care plan we found staff had updated their care plan in October 2016 and recorded, "There was no report of falls this month, [person`s name] is safe at all times." The fall risk assessment detailed that staff should refer the person to their GP, physiotherapist and the falls team if they had falls, however because staff had not recorded the correct information in the care plan this had not happened and the person was still at risk of falls. We observed this person being anxious and asking for staff`s support to use the toilet. They told us, "I would walk to go to the toilet myself, but I need them [staff] to help I can't walk myself. Every time I stand up I'm wet, I'm too much trouble for them." Staff were not always present to offer support and reassurance to this person. They were prompted to offer support to the person to use the toilet by the registered manager.

We found one person had sustained several injuries using a commode on three subsequent dates within one week. When we looked to see how this had been managed and reviewed we found no reassessment of the person's mobility needs had been undertaken and no referrals had been made to the GP to consider either deteriorating mobility or possible infection.

The registered manager told us that each day, senior staff led by a nurse completed a daily clinical walk around that reviewed those people at risk or with deteriorating health needs. However they did not

consistently review those people who had a fall, or a change in needs. For example, one person who had falls on 25 and 28 September 2016 did not have their needs reviewed regarding their safety, as staff had not communicated the increased risk of falls but they their nutritional needs had been discussed. As a result the senior staff were not aware and the person was not monitored more closely which left them at continuous risks of falls.

We saw for people at risk of either malnutrition or developing pressure ulcers, appropriate assessments were not carried out consistently. The assessment tool used for monitoring people's weights had clear guidance for staff in how to use the tool. The tool prompted staff to see a risk increase when a person lost more than five percent of their body weight over a period of time. However staff had not used the tool correctly and consistently not considered people's previous weight loss. For example one person had lost over four kilograms during a three week period; this did not trigger a review of their nutritional needs nor referral to their GP. A second person over three weeks had lost six kilograms. Staff had not reviewed the total weight loss at the end of the month. When we reviewed these, with the registered manager we found the overall risk was high and not medium as recorded in the care plan. The registered manager told us, "The nurses are not completing the Malnutrition Universal Screening Tool (MUST) cumulatively; we are arranging training with the quality training team to look at this."

People's medicines were not managed safely. We reviewed the MAR (Medication Administration Records) for five people, one of whom was considered by staff to have end of life care needs. This person had been prescribed pain relieving medicines in a form of slow release transdermal patches (these are patches applied on the skin and they slowly release pain relief absorbed through the skin over several days). However, after a review of this person`s needs, the GP amended the patch to a tablet form. Clear instructions were left by the GP that the patches were to be used until the tablets were received. However staff had not followed the instruction, the patch was not reapplied and the tablets were not available. This meant the person did not receive their medicine as prescribed and remained without any pain relief for four days until the tablets were received into the home. Staff had recorded that during this time the person had been crying and was in daily pain.

When we checked the stocks held for people's medicines, we found two out of five were incorrect. Staff had not recorded what had happened to a person`s medicine when they could not swallow it. This medicine was a strong pain relief which should have been returned to the pharmacy to be destroyed or be kept in lockable wall mounted storage. However there were no records and staff did not know what happened with the medicines when the person could not swallow them. We saw another person had not received their prescribed pain relief on 09 and 10 November 2016. Staff had not reported either of these medicine errors to the registered manager, and had not sought medical advice for people who missed their medicines.

We found that one person had their medicine crushed into their food, the nurse told us that this was due to them refusing their medicine. This had been authorised by the GP, but pharmacist advice about whether this was safe or appropriate had not been sought. When we asked the nurse why this had not been sought, they told us, "There was no pharmacy on Friday, so we did not check." This meant that there was a possibility that staff were administering medicine in a way that may have changed it`s effect.

We found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people's health and welfare were not sufficiently mitigated to keep people safe and people`s medicines were not managed safely.

Incidents or accidents were not always reported to the registered manager for review. As a result the registered manager was not reporting incidents which should have been reported to the local safeguarding

authorities and to CQC. For example one person had a percutaneous endoscopic gastrostomy (PEG) feeding tube to receive liquid food through the PEG as they were at risk of choking and unable to swallow. We saw staff recorded in this person`s daily notes that they found the person on one occasion chewing and coughing and they were at risk of choking. The person was given food by a visitor who was not aware of their condition. This incident had not been reported to the registered manager and no referrals were made to the local safeguarding authorities to ensure all avenues were explored in keeping this person safe from harm.

We found another person had not received any pain relief for four days. This incident was not reported to the safeguarding authority or the registered manager to ensure any lessons could be learnt and people safeguarded from harm.

Staff spoken with were able to describe the signs and symptoms of abuse and said they had training in how to safeguard people from any possible abuse. We found that from the 58 staff listed on the providers training matrix only 47 staff had completed and were in date with safeguarding people training, 11staff had not had the yearly refresher training. Staff were not sure of what their responsibilities were regarding reporting their concerns or how to follow up on their concerns. One staff member said, "We [staff] will mention concerns like bruising or skin tears and other incidents to the nurses. They [nurses] are supposed to record on the forms, take pictures and I think report further. We don't do anything else, maybe record in the daily notes." Another staff member said, "I don't know what happens after we report to the nurses. They are so busy we can hardly talk to them."

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes operated by the provider to identify and investigate possible harm were not effective. People were not always safeguarded from the risk of abuse.

People, visitors and staff told us there were not enough staff to meet peoples` needs safely and in a timely manner at all times. One person told us, "Yesterday I waited 30 minutes until they [staff] answered my call. The problem is they [staff] don't let us [people] know when they are busy and they cannot answer the bells." Another person said, "Soon after I came in I pressed the buzzer to help me go to bed. Someone came but said they were busy, but no-one came back. It was well past 10pm. So I put myself to bed and I've been doing so ever since." One visitor told us, "Sundays they seem to run on a skeleton staff. There was a person next door who was calling for help so I pressed the buzzer. Nobody came so I went looking for a Carer. [Person] was calling out all the time and it was upsetting us all. I couldn't find anyone on the upper floor, so I went to the lower floor and still couldn't find anyone. I eventually did speak to someone but it took ages for someone to get to [person]. It happens all the time. We had to wait at least 20 minutes once."

Care staff told us they had to go looking for the nurses every time they needed advice and guidance, however the nurses were not always able to help when needed because they were busy and not enough of them. One staff member said, "Even if we [staff] go to look for the nurses for advice or report something we cannot do it all the time. If they are medicating they cannot talk to us, so we just say to come and find us when they finish. Sometimes they come sometimes they don't. there are not enough nurses."

The registered manager told us there was a shortage of registered nurses. We found on occasions the vacant nursing hours were 121 in a week which meant there were three full time nurses short. These hours were covered by care staff however they were not qualified or skilled to meet people`s nursing needs. This meant there were both insufficient numbers of staff deployed to support people when required, and staff with the appropriate skills were not employed where required.

When we arrived at Wilmington Manor we found one person sat in the corridor distressed and calling out for

staff to assist them. We sat with this person for ten minutes until the registered manager arrived, however the person`s calls for assistance were not responded to by the care staff. When we went to find a member of care staff to assist the person we were unable to as they were all assisting people in their rooms, leaving no staff in communal areas to assist. A housekeeper staff member who was carrying out their cleaning duties in the area where this person sat did not intervene or attempt to console the person. They said to the person, "I can't help you [Person]; you will need to wait for one of the care staff." We observed that this made the person even more anxious and tearful. They told us, "I can't stay here; I am too much for them, I am such a nuisance."

We looked at how staffing was monitored in the home, and found that although the registered manager completed a monthly dependency tool. The dependency assessments were completed based on the assessment tools completed by staff. We found many assessment tools seen were completed incorrectly wrongly placing people at low, medium and high risk. As a result the calculations done in the dependency assessments were inaccurate in reflecting people's health needs and the time taken to meet these. As the registered manager was reliant on the dependency assessments to calculate staffing they did not consider there was a staffing issue.

The registered manager had not reviewed areas such as call bell response times. We looked at the response times for the day previous to the inspection and noted that some of the response times were excessively long. For example, one person summoned assistance at 19:31, and was not responded to until 20:07. On the morning of our inspection another person called for assistance and waited 16 minutes for staff to respond, a second person waited 34 minutes. When we asked the registered manager about monitoring call bells regularly they told us, "We did routinely monitor, then didn't; now I look when I am concerned about staffing. To review them [Call bell records] was difficult with staff time and who would do it, we just haven't got time to sit scrolling through."

The lack of staffing was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that assessments were not consistently carried out for people whose care plans detailed that they lacked capacity and were not able to take decisions or make choices. One person`s care plan stated, "[Person] is unable to make their own choices and decisions over their care." This person moved into the home in September 2016. Prior to moving into the home they had assessments of their needs completed by staff from the home and there were no psychological or dementia identified. The discharge summary from the hospital recorded that a diagnosis of dementia could not be confirmed during the person`s stay in hospital.

We asked staff about this person. One staff member said, "[Person] was a lot better (when the moved in the service) than now. They had difficulty talking and getting the words out, but they communicated well if given the time." Another staff member said, "I don't know much about [person] but they were able to make choices and tell us what they wanted."

We could not speak to the person on the day of the inspection as they were not well. However care records within the home clearly recorded the person had dementia and the care they received was planned around this diagnosis. There was no mental capacity assessment carried out for specific decisions and we found no evidence of a best interest process to make sure the care and support provided was in the person`s best interest. This meant that this person was at risk of receiving care and support which did not take account of their wishes and preferences.

Decisions made for people who staff considered to lack capacity had not been made through consultation with the registered manager, relatives or relevant professionals. For example, where people were considered by staff to lack capacity, bed rails had been put in place without assessing the persons capacity and considering if other options such as a profiling bed or crash mat would be more appropriate. Some people's relatives had informed the management that they had lasting power of attorney (LPA) to make decisions for their relative in relation to matters referring to their health or financial matters. However, when we asked to see how these had been verified, prior to a decision being made in behalf of a person, we found the list of people with an LPA was out of date, and many had not been verified. This meant that key decision may have been made for people such as treatment offered, fee's charged, end of life arrangements and restraints being placed, without the appropriate legal process being followed. For example one person's relative had signed and accepted the terms and conditions for their relative to reside at Wilmington Manor alongside payment of fee's without anyone verifying they had an LPA. This relative had developed the persons care plan, making key decisions around medication, how the person spent their day, personal care and matters affecting their choice.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people required a DoLS authorisation to maintain their safety, for example, using bedrails to prevent them failing from bed, the appropriate applications had not always taken place.

However we saw examples where the registered manager had completed the relevant applications to the local authority and DoLS had been authorised. Where these had been put in place the registered manager had regularly reviewed the conditions of the DoLS and the person's needs and reported back to the local authority. The process for both establishing capacity for a least restrictive option and subsequently completing the appropriate assessments was dependent upon an external professional assessor to complete, although the initial assessments should have been carried out by staff in the home.

With regards to the requirement for MCA and best interest decision for use of bed rails, the deputy manager told us the risk assessment and a general capacity assessment completed several months before the use of bed rails was sufficient to demonstrate that this was in people`s best interest. The deputy manager was unaware that specific capacity assessments are required for specific decisions. As they were the clinical lead for the home, it was their responsibility to identify and report to the registered manager when decisions needed to be taken in line with the Mental Capacity Act 2005.

We saw that the majority of the people whose care plan we saw had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) directive. Some were completed by the hospital following admission and had not been reviewed after they returned to the home although there was no indication that the decisions were indefinite. For example one person's DNACPR had been completed on 21 December 2015 and not reviewed since although the form had a printed section to be signed by their GP when the review took place. Another person's DNACPR had been completed in the hospital by a consultant. The consultant recorded on the form that neither the person nor their family had been involved in the decision. This has not been referred to the person`s GP when they moved in the home but it was recorded in their care plan that they had it in place. Other DNACPR's seen had been signed by a doctor and, and the person's relative who claimed they had the legal authority to make such a decision. However this had not been, verified. This meant that people were at risk of staff acting in a way which was not agreed by them and not necessarily in their best interest.

People told us staff asked them for their consent before they carried out any tasks. One person told us, "They [staff] ask me what I want and if it is ok. They are good really." Another person told us, "If I want anything I ask and they do it. So I am not complaining. They do ask if it is ok to help." Consent to care was not always documented in people`s care records.

The lack of appropriate arrangements to seek people's consent and to act in their best interests was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views about the skills and abilities of staff working at the home. One person told us, "Some staff are absolutely brilliant, some haven't got a clue." Another person said, "They always make sure I've got everything I need. I think they are good." A third person said, "Night staff are not very good, I don't think they are interested in the job. They don't know a lot."

Staff told us they had induction training when they joined the service and training was offered to them on a regular basis. One staff member said, "The induction training was very informative and then I shadowed the same more experienced care worker to learn the routine." Another staff member said, "When I joined I had an induction and then I shadowed staff. I feel I learned more by working really it is a shame the nurses have no time to spend and teach us more."

Staff we spoke with told us they felt supported by the managers and they had regular supervisions where their performance and development was reviewed. A staff member said, "The managers are very supportive and we have regular supervisions." Another member of staff said, "I can always approach the deputy manager or the manager for support. I do have supervisions."

Staff we spoke with were able to tell us the topics covered in their induction training for example, health and safety, infection control, manual handling and MCA/DoLS. However when we asked specific questions about their understanding of their training not all the staff were able to demonstrate they had understood or knew how to apply their learning. One staff member said, "Every person who lacks capacity should have an order (DoLS) in place, but we [staff] noticed for some people this section is blank in the care plan, so we have asked the nurses to complete it so we know what we are doing." Another staff member said, "We don't touch the care plans the nurses do. They are the ones telling us who has capacity or not."

Training records demonstrated that as of 1 November 2016 not all staff had the required training considered mandatory by the provider. For example, moving and handling training had been completed by 49 of the 58 staff. Nine staff members training had elapsed. We found similar concerns in areas such as food hygiene and fire safety. We saw 34 staff were identified by the registered manager as requiring pressure ulcer training. That nine staff out of the 34 had not completed the training. The registered manager told us the training team was in the process of updating the training records; however they were unable to provide assurances that staff had undergone this training.

People were referred to health care professionals if there was a need. However on occasions there was a delay in staff identifying people`s changing needs and health professionals input was not promptly requested by staff. For example when we asked a staff member about a person whose health was deteriorating and they were not eating or drinking much they told us, "[Person] used to eat well but two weeks ago I reported to the agency nurse that they were gaging on her food. The nurse told me to give [person] custard so they are not choking." When we checked the care plan for this person we found that their nutritional and hydration needs were not consistently recorded and when swallowing became difficult there was no evidence that this had been escalated and appropriate guidance and support sought from the GP or speech and language therapist (SALT) team.

People told us they saw their GP when they needed it. The local GP held a weekly surgery in the home so people and staff could raise non-urgent matters on that day. However we found one person who had complained of pain from 31 October 2016 staff had not asked for a GP visit promptly, they had waited for this person to be seen at the GP`s regular surgery on 03 November 2016. Speaking with people they said there had been no Dentist available since May 2016.

People said they enjoyed the food at Wilmington Manor. People were aware of the menu and the alternatives on offer if they didn`t fancy what was offered. One person told us, "The food is great, enough choice." Another person said, "They'll always make me an omelette if I don't like what is on offer." One relative told us, "The chefs are very helpful and they attend to requests even when it's not on the menu."

We observed lunch in the dining room. The dining room was well furnished, well lit, looking out on to the garden. Tables were nicely laid and decorated. Staff were serving and assisting people and two chefs supervising the food service. The staff were all engaging with people, talking, explaining, assisting and contributing to a pleasant atmosphere. There was some background music, which seemed to be at an appropriate volume.

Special diets were catered for and the chef showed us the food order book. There were drinks and sugar free

foods on offer for diabetic diets. The food request list, which was held by the chefs serving was comprehensive and gave information to the chef about the person`s diet, if they needed assistance and what portion size people preferred. For those with communication difficulties there were picture cards of all the foods available to enable them to choose what they liked.

Requires Improvement

Is the service caring?

Our findings

People`s dignity and privacy was not always promoted. It was clear when people could communicate that staff acted on their wishes. However for people who were unable to communicate and were in bed there were no details of how they wished to be supported and cared for. We found one person , who staff said was at the end of their life lying in bed with the door wide open and the radio playing loud modern music. When staff called in to change their position they left the door wide open again and the loud modern music still playing. Staff had not created a calm peaceful environment to promote this person`s dignity and privacy. We saw another person whose bedroom door had been left open and they had the radio on playing loud modern music. They could not communicate verbally to say if they wanted the radio on or their door open and their care plan had no detail about this. We found peoples preference about privacy and how they wished to be supported in their rooms was not routinely recorded in their care plans. This meant that dignity and privacy was not always promoted for people who were not able to verbally express their wishes.

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

People who lived at the home did not recall being involved in planning or reviewing their care plan and most people knew little about what their care plans contained. One person pointed at the observation charts in their bedroom used by staff to record different times and tasks completed for the person and called it the "Book of Rules". None of the people we spoke with read their care plan. One person said, "I don't know if I have a care plan, I never read or signed anything." They continued, "They [staff] only asked me what food I dislike and if I have any allergies nothing else."

We asked staff how they involved people in decision about their care. One staff member told us, "We ask people every day what they like and want so they can decide." Another staff member said, "I always talk to people. For example one person's care plan says they cannot communicate. I know they can. If I ask them to turn around so I can offer personal care, they do it so that's communication to me. People can indicate what they want and I listen."

People and their relatives told us staff were kind and caring towards them. One person told us, "The staff are excellent and all very attentive." Another person told us, "The attention they [staff] give is good. It really is a home with the emphasis on care." One relative told us, "The staff are excellent and caring. They always ask us if we want a cup of tea."

We saw staff developed positive and caring relationships with people who lived at the home. They called people by their first name and were respectful when talking to people. People told us they felt comfortable to approach any of the staff and were not afraid to ask for help at any time of day or night. The staff interacted politely with people and we observed people smiling and being cheerful when staff entered their rooms.

People were supported to maintain positive relationships with friends and family members who were

welcomed to visit them at any time. One relative said, "At first we thought we weren't allowed to be here at mealtimes. We found out that wasn't the case and we could even join [person] in the dining room."

Requires Improvement

Is the service responsive?

Our findings

People had mixed views about the care they received. One person told us, "They [staff] don't ask me what I like or when I want to go to bed. They just come in and switch the lights off so that's ` it." Another person said, "They're used to me now and I get up and go to bed when I want."

Care plans were generic and offered little guidance and information for staff to deliver care in a personalised way. Care plans were descriptive of people`s physical needs and what staff should do to meet these needs, however there was very little information to describe how people wanted to have their needs met. For example one person's care plan detailed that they needed two staff members to offer them personal care. However there was no detail for staff to know if the person liked to be washed with soap, shampoo, if they wanted to use a deodorant or a perfume and how they liked their hair to be done. Another person's care plan detailed that they were anxious and needed staff reassurance, however there was no guidance for staff in how to divert the person`s attention from their anxiety, what were they interested in and any conversation topics which could calm the person.

We also found where people were known to have behaviour which could be challenging for staff there was no guidance or care plan in place to instruct staff how to support the person with their behaviour. For example staff recorded that a person displayed behaviour which was upsetting for other people in the home. A relative also told us they complained to staff about this person`s behaviour, however staff said, "We can't do much, it is their home." We found there was no care plan developed to help staff understand the nature of the person`s behaviour, identify triggers and effectively manage the behaviour. The registered manager told us they didn't know about these behaviours and they would ensure a behaviour support plan was put in place.

For people who were not able to verbalise their preferences due to their level of dementia their care plans did not consistently or accurately reflect their life histories, personal circumstances or preferences. This meant that new and temporary staff members who were less familiar with people did not always have access to the information and guidance necessary to help them provide person centred care and support.

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

People told us there were activities organised in the home and it was up to them to decide if they wanted to attend. One person said, "There is something going on often, but I don't want to go. I am not very sociable." Another person said, "More outings would be nice, but they [staff] do what they can. We wanted a pet and we got a budgie. We also have a dog coming around."

People had access to activities organised by a care worker who was covering the activity organiser position until the activity coordinator position could be filled. The care worker was supported by a volunteer one day a week, hairdresser once a week and a regular entertainer. There was a weekly activity plan however it was neither available in bedrooms nor displayed on noticeboards. No activities were planned at weekends. One

half day a week was designated to people unable to leave their rooms. The care staff told us that the activities for the day were "spread by word of mouth." We observed a `pampering` activity on the day of the inspection. Around 10 people attended and were seen to be engaged in the activity, chatting to each other and some were singing along to background music. There was a happy atmosphere and the care staff were enthusiastic and able to keep the group entertained.

Most people told us that they never formally complained and could not give us feedback if their complaints would be listened to. One person said, "I didn't complain just moan sometimes because they are short staffed and the laundry is not brilliant, things don't return." We didn't see any information available on making a complaint displayed around the home. There was a notice on "Feedback" next to the Reception desk prompting visitors to leave feedback about the service. One staff member said, "If someone has a complaint we like to deal with it straight away before the form is filled in."

When complaints were reported to the registered manager these were logged and investigated in line with the providers policy. Copies of the complaints policy were available for people who lived at the home and those who visited. As part of the providers monthly visits they reviewed complaints that had been reported to the registered manager to ensure these had been swiftly responded to. The registered manager maintained a log of the complaints received, which showed people had been informed of the outcome and the actions taken. However, complaints were not used as a learning tool to discuss with staff or review the service. We saw that fifty percent of complaints received between July and November 2016 related to staff attitude, each had been reviewed, however no record of discussion or action plan to address the concerns had been developed. Learning outcomes were not shared with staff in team meetings to ensure they could improve the service.

Meetings had been held with residents and relatives where matters relating to the home were discussed and people could speak directly with the registered manager about improvements. Where people raise requests or suggestions these were acted upon. For example, people asked for a pet bird for the home, and one was duly purchased and placed in the communal lounge for all to enjoy. The minutes of these meetings demonstrated that people were kept informed of developments in the home such as staffing changes, new admissions, and developments such as on-going work to provide people access to phones and a home wide broadband connection. This meant that although complaints were responded to, they did not form part of the registered manager's review of the quality of care provided to people.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives did not know who the registered manager for the service was. One person said, "I don't really know who's in charge. I see so many I don't know their names". One relative said, "There is someone in charge but I don't know their name. They come into the room occasionally when I've been in there." Another relative said, "This place is run excellently. I've got several friends in other places and this place is by far the best".

There were no robust systems in place to ensure people's care was routinely reviewed and monitored. We looked at the actions set by a local authority review of three people's care in August 2016where a number of areas were identified as requiring improving. For example s a person required a capacity assessment for use of bed rails, a lack of involvement in developing and reviewing people's own care, and lack of appropriate actions in response to people`s weight loss. We reviewed the same three people's care records and found none of the actions had been addressed. We also found similar omissions in other people's records. There was no monitoring or reviews done by the registered manager to improve the care people received in the areas identified by the local authority.

On a daily basis, staff carried out a `take ten` meeting and a daily clinical walk round. The take ten meeting, with the senior team, addressed issues and actions required for that day, such as staffing, maintenance, people's nutritional needs and administration. Daily actions from these were set and carried forward where needed. However, the attendance for these meetings varied, with, on the day of inspection, only maintenance staff attended. We looked at the daily clinical meetings and found that these were not completed at weekends, meaning incidents, injuries, tissue viability, nutrition, and safety was not reviewed at those times. The provider`s policy required these to be completed daily, however these had not happened for a significant period of time. The lack of the daily clinical meetings was not identified by the registered manager or the provider as an area needing improving.

A survey about the quality of the care provided to people had been sent recently to people and relatives and responses had not yet been received. We looked at the results of the previous survey done in 2015. Following the survey three areas were identified as requiring improvement which were answering call bells promptly, staff being available when needed and for staff to know people and their needs. These areas had all been reviewed by the registered manager and signed off as completed in March 2016; however we found that in all these areas improvements were still required.

The current service improvement plan from a provider visit in October 2016 identified areas such as the clinical risk board to be updated, health and safety audits to be completed, and to update people's personal allowances. The provider's representative and the registered manager told us that the home improvement plan incorporated findings from CQC, the local authority and their own internal audits. However, upon reviewing we found these did not correlate. We also found that care records, assessments, nutritional audits with the cook, medicines management and staffing reviews had not effectively identified the concerns addressed throughout the inspection.

The provider required that staff meetings were held quarterly, however we found that the last meeting prior to our inspection was in June 2016. The minutes demonstrated that issues discussed were call bell response times, supervision and appraisal completion and staff morale in the home as a number of staff had left. The registered manager submitted to us the minutes from a meeting held on 20 November 2016 which showed the issues raised in the previous meeting had not been reviewed or discussed, and continued to be areas requiring improvement.

Actions needed to improve the quality of the service were detailed in the home improvement plan, provider visits, daily clinical walk around and different audits. We saw that the actions were not robustly addressing all the issues. For example where actions were set, there was no date set as to when they should be completed nor the steps needed to both address the concern and monitor the impact of the improvements The provider had the management tools in place to continually monitor the service; however these tools had not been used effectively to identify, report, respond to and monitor the improvements required.

We looked at a copy of the Provider Information Return (PIR) submitted to CQC in April 2016. This documented several areas where the registered manager felt the service required improvement. Several areas of actions identified in the PIR had not been addressed or monitored by either the registered manager or the provider. For example the PIR recorded that senior carer positions needed increasing, a staff champion scheme in areas such as nutrition would be introduced and the quality auditing would be improved in a more timely manner. The registered manager had identified that staff required protected time to enable them to complete this. When we inspected the home seven months after this plan was submitted we found improvements had not been made or sustained in these areas.

People's care records were not completed to ensure an accurate record of the care a person required was maintained. People's care records were reviewed by staff regularly, however the information contained in them was not detailed enough around people`s mental capacity, mobility needs, skin integrity, behaviour management, risk management or person centred care. Daily care records evidenced people`s changing needs; however the care plans and risk assessments were not promptly updated to reflect these changes. For example we found for one person the daily care records and accident forms detailed they had three falls in a month, however their mobility care plan and fall risk assessment was updated to say they had no falls in that month.

Incidents and injuries were recorded and information about numbers of falls were kept by the registered manager, however they were not analysed to try and identify trends and patterns. Where people were referred to other health care professional's staff were not following up on the appointments. For example we found that in June 2016 staff discussed with the GP to refer a person to the physiotherapist and Parkinson nurse because of their frequent falls. However, when we inspected the service staff had no update on when these visits were to happen.

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

The Registered Manager carried out night visits for routine monitoring or when they had concerns. We saw one occasion they carried out a night visit at the home in response to concerns raised about medicines management for one person. No issues were found, and the registered manager ensured they checked people had received enough fluids, medicines, and that staff were present.

The registered manager throughout the inspection was found to be transparent and honest, which was clearly an approach they expected from people working and living within the home. Minutes of resident and

relative meetings demonstrated they spoke regularly about CQC inspections, and discussions were held where the registered manager spoke to people about the need to be open and honest with inspectors so an accurate view of the quality of care was found.

The registered manager had implemented a one to one surgery for staff to meet with them. This had been following feedback from staff that they were difficult to speak with or approach due to their commitments. We saw that the response from staff had been positive and a number had held a one to one meeting with the registered manager to raise issues or seek support. One staff member told us, "The manager is very good. They listen and help when they can."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People received care and support which didn't always take account of their likes, dislikes and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The care and support people received was not always promoting their privacy and dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The MCA 2005 principles were not followed in relations to mental capacity assessments for people who may have lacked capacity and best interest decisions were not made for people following a best interest process.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes operated by the provider to identify and investigate possible harm were not effective. People were not always safeguarded from the risk of abuse.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

There were insufficient numbers of suitably skilled staff available and deployed to meet people's needs consistently across all areas of the home at all times.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks to people's health and welfare were not sufficiently mitigated to keep people safe and people`s medicines were not managed safely.

The enforcement action we took:

Warning notice served under Section 29 of the Health and Social Care Act 2008 because the provider and registered manager failed to comply with Regulation 12, (1) (2) (a) (b) (c) (g) (i), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to monitor and mitigate the risks relating to the health, safety and welfare of people. People`s care records were not always accurate or contemporaneous in reflecting the care and treatment they received.  The provider`s quality assurance systems were not effective in identifying all areas in need of improvement.

The enforcement action we took:

Warning notice was served under Section 29 of the Health and Social Care Act 2008 because the provider and the registered manager failed to comply with Regulation 17, (1) (2), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.