Care UK Community Partnerships Limited

Mill Lodge Care Centre

Inspection report

1a Moorside place, Thornbury, Bradford BD3 8DR
Tel: 01274 668874
Website: www.careuk.com/care-homes/mill-lodge-bradford

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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

Overall summary

This inspection took place on 22 & 23 January 2015 and was unannounced. At the last inspection on 5 September 2013 the home was found to be meeting the requirements we assessed.

Mill Lodge Care Centre provides nursing care for up to 42 older people, including some who are living with dementia. There were 41 people living at the home when we visited, which included one person who was in hospital. Accommodation is provided in single ensuite bedrooms in two separate units, one on the ground floor and the other on the first floor. Lift access is provided between the floors. There is a communal lounge and dining room on each floor as well as toilets and bathroom facilities. A central kitchen and laundry are located on the ground floor. There is secure parking and garden areas.

The home did not have a registered manager. The registered manager resigned in December 2014 and a new manager had been appointed who had been in post four days when we inspected but had worked at the home as a support manager since September 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People told us they felt safe, although they said they thought more staff were needed and this was confirmed by our observations. We found staff understood safeguarding and knew how to recognise and report abuse. However concerns were raised with us about how one accident was dealt with by staff and we identified two safeguarding incidents where it was not clear if appropriate action had been taken with regard to staff involved in these incidents. Following the inspection we made a safeguarding referral and spoke with the regional director. We received evidence from the provider which showed they had liaised with the safeguarding team and these issues had been addressed.

People received their medicines when they needed them and arrangements for managing medicines were safe, although we found three discrepancies in the recording of medicine stock levels, which meant some medicines were unaccounted for.

Staff understood the legal requirements relating to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS authorisations were in place for two people and other applications had been made for an assessment to ensure people were not unlawfully deprived of their liberty.

Staff recruitment processes made sure staff were safe and suitable to work with people. Staff received induction and ongoing training and support to meet people's needs.

People were involved in planning their care and some care records were detailed, however others records we saw had contradictory information which meant there was a risk people may not receive consistent care. People had access to healthcare services and we found staff were prompt in bringing in healthcare professionals when people's needs changed.

People's dietary needs were met, although people told us the food was variable in quality. We found mealtimes were not a relaxed and sociable occasion and people did not always receive the support they needed to eat their meals in a dignified way.

People told us staff were kind and caring and although we observed some good interactions we also saw some staff did not respond in a caring way to people and showed a lack of respect.

Although staff had started to involve people in activities, we found a lack of social engagement and activity for people on the upstairs unit, the majority of whom stayed in their rooms. The manager told us they were looking at ways in which this could be addressed.

We looked round the home and found the premises were clean and well maintained. Records we

saw showed equipment was regularly serviced and environmental risk assessments had been completed. However, although the home was decorated and furnished to a high standard we considered further adaptations were needed to help people living with dementia find their way around. For example, by the use of appropriate signage, lighting and colour schemes.

The provider's quality assurance systems had identified many of the issues we found at this inspection and we saw actions had been identified to address the shortfalls which the new manager told us they were in the process of implementing. Our discussions with the regional director following the inspection and evidence they sent showed they had taken immediate action to address concerns we had raised at the feedback session at the end of the inspection and progress was being monitored by unannounced visits from the governance team.

We identified a number of breaches of regulations. You can see what action we have 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. People told us they felt safe, although they thought there should be more staff. We found there were not always enough staff to meet people's needs. Recruitment processes ensured staff were suitable and safe before they started working with people.

Staff understood how to recognise and report abuse, however, one safeguarding incident had not been reported to the Local Authority and one accident had not been fully investigated.

The premises and equipment were well maintained.

People received their medicines when they needed them and medicines were stored and given safely, although we found three discrepancies in stock levels recorded on individual administration charts.

Is the service effective?

Requires Improvement

The service was not always effective. Staff were inducted, trained and supported to ensure they had the skills and knowledge to meet people's needs.

People's nutrition and hydration needs were met, although people told us the quality of the food was not consistent. We found the dining experience was poor with people not given the support and assistance they needed to eat their meals in a dignified way.

The legal requirements relating to Deprivation of Liberty Safeguards (DoLS) were being met.

People were supported to access health care services to meet their individual needs.

Adaptations were required to the environment to make it more 'dementia friendly' which would help people living with dementia find their way around more easily.

Is the service caring?

Requires Improvement

The service was not consistently caring. People told us staff were "nice" and "good" and we saw people were relaxed around staff.

However, although some staff treated people kindly, we also saw occasions when staff failed to treat people with respect and did not respond in a caring way to people's needs.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People were involved in planning and reviewing their care. Although some care records were detailed, others were incomplete.

People were offered a range of activities, although we saw for people on the upstairs unit there were fewer activities taking place.

People knew how to make a complaint and we saw complaints were recorded and dealt with.

Is the service well-led?

Requires Improvement

The service was not consistently well-led The home had a new manager who was applying for registration with the Care Quality Commission.

Quality assurance systems were not implemented consistently, which had been identified by the senior management team and actions had been taken to begin to address the shortfalls.

However, these improvements needed to be sustained and developed further to make sure people consistently receive high quality care.

Mill Lodge Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 23 January 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors and an expert by experience with expertise in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the home and statutory notifications we had received from the home. We also contacted the local authority contracts and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We usually send the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not send a PIR to the provider before this inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We spoke with nine people who were living in the home, three relatives, three care staff, an agency care worker, two nurses, the activity co-ordinator, the cook, the administrator, the deputy manager and the acting manager. We also spoke with a visiting speech therapist from the Speech and Language Therapy (SALT) team.

We looked at five people's care records in detail and two to follow up on specific information, two staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe in the home, although they said they felt there could be more staff on duty. One person, when asked if they felt safe in the home, said, "Yes I do, I don't really have to think about it." Another person asked us if the home was required to have a certain number of staff on duty and, when asked why, said, "Because sometimes during the day when they are bathing people or taking people to the dining room there doesn't seem to be enough of them."

We observed there were insufficient staff to meet people's needs. In the communal areas downstairs, we found a lack of care staff, although an activity organiser was present and responded to requests for care and support from people by finding care staff to assist.

Staff told us the dependency levels on the upstairs unit were high as nine people needed assistance or prompting with their meals and three people were on 15 minute checks throughout the day. On the first day of our inspection there was a nurse, two senior care staff, one agency care assistant and one care assistant on duty for 23 people. However, the two senior care staff were supervising two students who were on work experience placements as well as both care staff. One of the senior care staff told us two staff were allocated to give out breakfasts while the other two staff helped people to get up. We saw staff were still assisting people with washing and dressing after midday and finished shortly before lunch was served at 12.40pm. We found one female, who was on 15 minute checks, in their night clothes in the bedroom of a male who was in bed. The female was stood in the ensuite drinking directly from the male person's water jug. Staff were unaware this person was there until we alerted them and they then escorted the female back to their room. Care records showed this person had sustained eight falls in the last month despite 15 minute checks being recorded. Staff told us no one was allocated to carry out the 15 minute checks and they were just done by whichever staff member was passing by. Care records showed sensor mats were to be used when this person was in their chair or bed so that staff were alerted when the person left their room. However, there was only one sensor mat in the room which was under the bed and we saw the person moved freely between the bed and their chair. This meant when the person was in their chair staff were not alerted as the sensor mat was not in place.

On the second day of the inspection we observed there were no staff out on the floor on the upstairs unit for a period of 14 minutes while the day staff were receiving handover from the night staff in the office. During this time we observed people calling for assistance and stayed with one particularly distressed person until the handover was finished. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nurses we spoke with were aware of how to detect signs of abuse and knew how to make referrals to the local authority safeguarding team and the Care Quality Commission (CQC) if they had any concerns. They were aware of the whistleblowing policy and felt any concerns they raised with the manager would be taken seriously. Two care staff we spoke with had a limited knowledge of safeguarding and whistleblowing and the circumstances in which action may be required but they understood their responsibilities in protecting vulnerable people.

During the inspection whistleblowing concerns were raised with us about how staff had responded to an accident where a person had sustained a fractured hip. We reviewed the records relating to this accident and found there was conflicting information about what had happened. We discussed this with the acting manager who agreed the records were not clear and, although they said they had spoken with the staff involved, there was no record to show any further investigation had been carried out to establish the facts. We found two other safeguarding incidents where it was not clear if appropriate action had been taken with regard to the staff involved in the incidents. Following the inspection we made a safeguarding referral and raised our concerns with the regional director. The regional director investigated the incidents, liaised with safeguarding and provided a full response which showed that following their investigation appropriate action had been taken to address the concerns.

We were provided with a list of accidents and incidents that had occurred over the previous year, some of which were safeguarding matters. Following the inspection we asked

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Is the service safe?

the manager to confirm what action had been taken in response to these incidents and if safeguarding referrals had been made. We received information from the manager which showed these incidents had been dealt with appropriately and safeguarding referrals had been made where required, apart from one incident. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with and records we saw showed safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) and references, were obtained before staff began work. Records showed there were effective systems in place which ensured nurses' registration with the Nursing and Midwifery Council (NMC) was valid and up to date.

We looked at a sample of bedrooms and all communal areas and found the premises were clean, tidy and well maintained. We saw maintenance certificates were in place and up to date for all equipment and the premises.

We found there were safe systems in place to manage people's medicines. We observed nurses administering medicines during two separate medicine rounds and saw people were supported sensitively to take their medicines and given preferred drinks as recorded in their care plans. Medication administration records (MAR) we reviewed were complete and contained no gaps in signatures. We saw that any known allergies were recorded on the MAR.. We asked the nurse about the safe handling of medicines to ensure people received the correct medication. Answers given demonstrated that medicines were given in a competent manner by well trained staff.

We saw evidence that people were referred to their doctor when issues in relation to their medication arose.

Annotations of changes to medicines in care plans and on MAR sheets were signed by the GP. All 'as required' (PRN) medicines were supported by written instructions which described situations and presentations where PRN medicines could be given. The provider had compiled protocols for the administration of certain medicines which required specific rules to be observed. For example, we saw protocols were available for the administration of warfarin where the dose is determined by periodic blood tests.

We saw that one person was receiving their medicines covertly. We saw the covert administration was taking place in the context of existing legal and good practice frameworks. There was evidence of an assessment of mental capacity. A best interest meeting had taken place with the inclusion of relevant health care professionals, including a pharmacist, and family members. The original decision was taken in November 2013 and we saw a review had been conducted by the GP and family members in September 2014.

We found medicines were stored securely and storage facilities were clean and well organised. Drug refrigerator and room temperatures were checked and recorded to ensure that medicines were being stored at the required temperatures. Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw that controlled drugs were stored securely and records were accurately maintained.

We carried out a random sample of supplied medicines dispensed in individual boxes. We found on four occasions the stock levels of the medicines did not concur with amounts recorded on the MAR sheet. **We recommend that the service considers the National Institute for Health and Care Excellence (NICE) Guidelines for Managing Medicines in Care Homes.**

Requires Improvement

Is the service effective?

Our findings

People told us the standard of food was variable. One person said, "The food can be 'off' sometimes because the kitchen staff are up and down." Another person said, "Sometimes the meat might be a bit chewy." A further person described the food as, "Okay."

We met with the cook on duty. This staff member told us their usual role was a senior care assistant. They told us they had no formal cooking qualifications although they confirmed they had completed food hygiene training. The staff member said a new chef had been appointed but was working at another home which meant they were covering the cooking duties for the day. They said the new chef had developed new menus however these were not available for us to review. The staff member told us there was no list in the kitchen of people's likes or dislikes or any special diets.

We observed the lunchtime meal on both units. There was no menu on the upstairs unit to inform people of the meals and staff did not know what was for lunch until the food arrived. Although we saw a menu displayed in the reception, this did not accurately reflect the meal that was served. For example, the dessert on the menu was jam sponge and custard, yet what was served was crumble and custard. The nurse told us, "We used to have menus up here, but don't now." Although some people on both units were living with dementia we did not see choices offered in an accessible format such as using pictorial menus or 'show plates' so people could see the food. This meant people were not supported to make informed choices about their meal.

We saw the food served was hot and people were offered a choice of meals and drinks. However, we questioned if this was normal practice as one person commented, "Nice that they've asked, they usually plonk it on."

Some people had napkins and others were offered protective clothing to keep their clothes clean. Some people were offered plate guards to aid them. We saw two people had pureed meals and each component of the meal had been pureed separately so that people could distinguish the different tastes. However, when we asked the staff what the pureed meal was they did not know.

We saw food and fluid charts were completed for those people who needed them. However, some charts did not have a target fluid intake and it was not clear how these charts were monitored and reviewed consistently to determine if people had drunk enough throughout the day.

On both units we found lunch time experience was task orientated with no ambience. On the upstairs unit we found the meal time was poorly organised with staff moving from one person to another and although there was a nurse present there was no direction or supervision of staff. For example, we saw one staff member stood over a person trying to assist the person with their meal. When the person was reluctant to receive their help they walked off. We saw one of the students who was on a placement was directed by staff to assist one person with their meal. The student said they did not know what to do and the staff member said, "Just help her". The student stood over the person and tried to give them their meal with a spoon using their name to encourage them. It was another person who was sat at the same table who told the student that the person was not called the name they were using. The student and staff laughed in response. We saw five people in wheelchairs struggled to eat their meals as they could not get close enough to the table. This was because the tables were not high enough to accommodate the arms of the wheelchair. We saw this compromised people's dignity as they struggled to get food from their plates to their mouths without it dropping down their clothes. We saw one person trying to eat a bowl of soup by dipping their fingers into the soup and sucking on them. This meant the soup dripped all down the person's arm and all over their clothes. Staff were present and occasionally tried to persuade the person to use a spoon, but the person made it clear they did not want to, however the staff did not offer any other options which may have helped the person, such as giving the soup in a cup. We saw another person leaning forward in their wheelchair with their mouth balanced on the edge of the bowl so that they could eat their meal without spilling it. Again staff took no action to make this person more comfortable when eating their meal. In the morning we had seen a person in bed who was struggling to eat their breakfast as they had not been sat up properly. We saw most of their breakfast had fallen onto their chest. This was in breach of regulation 17 of the Health and Social

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Is the service effective?

Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were satisfied with the care they received. One person said, "It's a decent sort of place and they look after me well." Another person said, "I like it here, they (the staff) know what they're doing."

The manager provided us with an up-to-date training matrix which used a colour coded system to identify when training updates were due. This showed some updates were overdue, which we saw had been identified in a quality monitoring visit report in September 2014 and a deadline given for staff to complete by November 2014. This had not been followed up by the previous manager who had carried out an audit in November 2014. However, the current manager told us they had reviewed the training and staff had until the end of the month to complete any outstanding training and this was confirmed in records we saw. This was being monitored by the manager and through quality monitoring visits by the governance team.

Care staff told us they had received a good induction and had worked alongside more experienced staff until they were confident and competent to care for people on their own.

We spoke with the manager about staff supervision and appraisals. We saw from records the previous manager had not kept up-to-date with staff appraisals. However, records we saw showed in the previous nine weeks appraisals the manager had almost completed appraisals for all staff; those that were still outstanding had a date arranged for the appraisal to take place.

During our inspection we saw people were able, individually or through their relatives, to express their views and make decisions about their care and support. We saw staff seeking consent before supporting people with their needs. When people were not able to communicate verbally we saw staff accurately interpreting body language to ensure people's best interests were being met. Our discussions with people, staff, and records we reviewed showed consent was sought and was appropriately used to deliver care.

We spoke with a relative of a person who was subject to Deprivation of Liberty Safeguards authorisation (DoLS) regarding their involvement in decision making and consent. The relative was the relevant person's representative as defined in the Mental Capacity Act 2005 (MCA) and as such had legal powers to speak on the person's behalf. The relative told us all aspects of care had been discussed with them at the time of admission. They said, "I visit almost every day and my wishes on behalf of [name] are always complied with; I am completely happy with everything here".

The Care Quality Commission (CQC) monitors the operation of the MCA and specifically DoLS which applies to care homes. Ten people at the home were either subject to DoLS or applications had recently being made to the local authority and were awaiting assessment. Discussion with the manager demonstrated a good understanding of the legal framework in which the home had to operate to secure a valid DoLS authorisation. However, the previous manager had not complied with Regulation 18 of the Care Quality Commission (Registration) Regulations. The regulation requires any request to the supervisory body made pursuant of Part 4 of Schedule A1 of the 2005 MCA by the registered person for a standard authorisation to be made known to the Care Quality Commission (CQC) without delay. No notifications had been made. We discussed this with the manager who submitted the notifications on the second day of the inspection.

We saw that care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff who knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

We spoke with nursing staff about the lawful use of restraint. Staff were able to describe what restraint meant and could distinguish between restraint for people who have the ability to consent and those who lack capacity. Staff also had a good understanding of the need for a proportionate response to the likelihood and seriousness of harm.

Records showed that arrangements were in place that made sure people's health and social welfare was protected. We saw evidence that staff had worked with

Is the service effective?

various agencies and made sure that people accessed other services in cases of emergency, or when people's needs had changed. This had included GPs, hospital consultants, psychiatrists, community nurses, speech and language therapists, opticians and dentists. We spoke with a speech therapist from the Speech and Language Therapy (SALT) team during the inspection. They told us the team visited the home regularly and found staff were good at contacting them if they had any concerns. They said the staff followed any advice and guidelines they gave.

We saw on one occasion a person had been identified as showing signs of rapidly declining mental health. From care records we saw that the GP had been alerted to the issue who had in turn arranged for a psychiatrist to examine the person. Annotations in the care file by the psychiatrist gave professional advice to the GP to try a new medicines regime. We saw the changes made to the person's MAR as a result. This demonstrated the provider had been aware of people's changing health care needs and had responded appropriately.

We found the home was comfortably furnished and decorated to a good standard. We saw there were different areas in the home where people could go to spend time with one another or alone. However, we considered improvements were needed to help people living with dementia manage their surroundings, retain their independence, and reduce feelings of confusion and anxiety. For example, by the use of appropriate signage, floor, lighting and colour schemes. **We recommend that the service explores the National Institute for Health and Care Excellence (NICE) quality standards for people living with dementia under Quality Standard 30 (QS30: Supporting people to live well with dementia) and Quality Statement 7 (design and adaptation of housing) on how premises can be designed or adapted in a way that helps people with dementia manage their surroundings, retain their independence, and reduce feelings of confusion and anxiety.**

Requires Improvement

Is the service caring?

Our findings

People spoke positively about the staff who they described as 'good' and 'nice'. One person said, "The staff are good to me, they're nice." Another person said, "The nurses are nice here". A further person said, "The staff are nice, it's like anywhere else, there are some nice staff and some not so nice."

We saw people appeared at ease and relaxed in the home and were comfortable in the presence of staff. We saw people responded positively to staff with smiles when staff spoke with them. We observed that staff included people in conversations about what they wanted to do and explained any activity prior to it taking place. People looked well cared for, clean and tidy. People were dressed with thought for their individual needs and were well groomed. We saw some people chose to stay in their rooms and observed staff called in whenever they could to say hello and check people were all right.

We saw inconsistencies in staff practices which impacted on the care people received. We saw some staff practices were respectful and promoted people's privacy and dignity. For example, we saw staff knocked at bedroom doors before entering, even when it was clear the room was empty. We saw staff ensured people's privacy and dignity was maintained when carrying out personal care tasks. We saw staff were caring and responded quickly when people were uncomfortable. For example, one person was asleep in an armchair with high back and wings. After twenty minutes a member of staff approached them and said, "Would you like a pillow, you are going to get a crick in your neck". The staff member then came back thirty seconds later with a pillow to support them. On two other occasions we saw staff assisted two people in wheelchairs to be seated more comfortably.

However, we also saw some staff did not always recognise or respond appropriately when people's dignity was being compromised. For example, at lunchtime we saw people were not sat close enough to the table which resulted in them dropping their food and struggling to eat their meals. Whilst we saw staff caring for people with kindness, this was not always in a respectful and individual way. For example, we heard one member of staff regularly referring to one person as 'Mama' and calling other people 'sweetheart', 'sweet pea' and 'flower', terms which may be demeaning to people. We saw one person was having their room decorated. The person had been admitted to hospital as an emergency a few days prior to our visit. Whilst it was good the provider was maintaining a suitable environment we saw no evidence that the person had been consulted on the redecoration. We saw one person in the morning was given a cup with a lid on and was not able to tip the cup up fully to finish the drink due to weakness in their hands. We saw at lunch time the same person was given a cup without a lid and managed to drink it all. We checked this person's care plan which recorded the person had weakness in their hands but mentioned nothing about which type of cup this person would require. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff to gauge their knowledge of people they were caring for. Staff had a good knowledge of key moments and events in people's lives. They knew who people's nearest relatives were and the frequency of visits.

Care records we reviewed had information that showed people's care needs had been discussed with them and/or their relatives. We were told of two people who lacked the mental capacity to make decisions for themselves and had no family or friends it would be appropriate to consult with. We saw the local authority had instructed an Independent Mental Capacity Advocate (IMCA) to support both people when important decisions or reviews of care need are being made. The manager was aware of the appointments of an IMCA and knew of the need to involve them in decision making.

Requires Improvement

Is the service responsive?

Our findings

We looked at five people's care records. Information was kept electronically as well as in a paper format and we found inconsistencies in the care records we reviewed. Three of the care plans we saw were person centred, with individual information on people's wishes in relation to how their care was provided. The care plans showed how people liked to spend their time and how they liked to be supported. The plans also showed what people or their relatives had told staff about what provoked their anxieties and behaviours. We saw that when care plans were initially constructed and subsequently reviewed close relatives were involved in the process. We saw care plans in place for people with dementia who were coming to the end of their life. We saw evidence of a palliative care approach. Care plans considered physical, psychological, social and spiritual needs of people to maximise the quality of life of people and their family.

However, the other two care records were incomplete and contained contradictory information. For example, one person's care plan about sleeping stated bed rails and bumpers were used, yet another assessment showed bed rails were not used as they were not suitable or safe for this person. For another person, who was in hospital, the paper care plans were blank and some of those on the electronic system had not been completed such as 'what's important to me', what people like or admire about me' and 'how best to support me'. We also saw there was no end of life care plan for one person specifically admitted to the home for palliative care.

Care planning was largely developed out of dependency assessments completed at the point of admission. The assessments covered such issues as mobility, tissue viability, continence, eyesight, hearing, memory and nutrition. We found the assessment format limited the care planning process as staff were not encouraged to consider people's needs more widely which gave rise to incomplete or confusing care planning. For instance, for one person we saw information recorded to assess mobility and the risk of falls. The assessment noted the person had a sensory deficit which impacted on balance, that the person's gait was unsteady and they had restricted mobility. However, there was no information to show the person had an above knee amputation, because this question was not asked. This showed that there was an incomplete or inaccurate assessment of some people's needs which meant there was a risk of inappropriate care.

We looked at the care plans for three people who were at high risk of developing pressure ulcers and were nursed on pressure relieving mattresses, For two of these people we found the care plans for skin integrity were well completed and included the pressure mattress weight setting level which we saw was being followed correctly when we checked the mattresses. However, for the other person there was no weight setting level recorded and when we looked at the mattress with the nurse they were uncertain how this could be determined on the equipment provided. The nurse agreed to check this straightaway as the wrong setting could cause, rather than prevent, skin damage.

We observed the morning handover between the night nurse and the day staff on the second day of our visit. The information handed over was limited and provided minimal detail of how people's care needs had been met or changed overnight. For the majority of people the nurse stated they were either 'okay' or 'alright'. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us the home employed two activity organisers who worked part time, however they had recently employed a full time activity coordinator which would increase the activity provision to 42 hours per week. We saw some people had memory and life history articles in their rooms which informed staff about their individual interests. We spoke with the activity organiser who told us they discussed interests and hobbies with people during one to one conversations in the morning. We saw opportunities were provided for people to go out shopping, on trips to the pantomime and on walks in the garden. The activity organiser told us they were working with people to gain their opinions on what they would like to do and form feedback given had started bingo, quizzes and reminiscence sessions. On the unit downstairs we saw there was a lot of social engagement with people and the activity organiser spent time with people in the communal areas. In contrast on the unit upstairs we found social activity was limited. We saw the majority of people stayed in their rooms and there was no one in the communal lounge. The lounge was a small room which was

Requires Improvement

Is the service responsive?

comfortably furnished but apart from the television there was nothing to interest or occupy people. The manager told us they were working with staff to look at ways in which they could encourage people to come out of their rooms and spend time in the communal areas.

People and relatives we spoke with told us they had no complaints about the service but knew how to make a complaint. People we spoke told us they felt able to speak out if they were concerned about anything. They said they would not hesitate to raise any concerns. Most said they would speak to the manager or one of the nurses. One person said, "I'd go to the office if anything was wrong." We observed another person expressed their feelings to a staff member who listened and responded.

We saw a copy of the complaints policy, which included contact details for the Local Government Ombudsman and the Care Quality Commission. We saw the complaints log which provided evidence of the complaint, the investigation, action taken in response and how the outcome was communicated to the complainant.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager who left the post mid-December 2014. A new manager had been appointed who had been in post four days when we carried out the inspection. They told us they had worked at the home as a support manager since September 2014. The manager was open with us and acknowledged that improvements to the service were required. They said they had the support of the senior management team to make improvements.

We found some of the audit systems in place were ineffective as there was no analysis of the information collated or evidence to show that action had been taken to address issues identified. For example, we were provided with an audit of people's monthly Malnutrition Universal Screening Tool (MUST) scores and weights for December 2014. Although there were some handwritten notes where people had a low Body Mass Index (BMI) these provided minimal information. For example, for one person with a BMI of 16, which means the person is underweight, the handwritten note stated 'Dietician – Fresubin'. We found there was no analysis of incidents and accidents that had occurred in the home, although the deputy manager told us they had carried out a monthly analysis in December 2014 they were unable to provide us with this report. We saw from a recent quality assurance report that the shortfalls in the audit processes had been identified by the Clinical Development Manager and an action plan was in place with timescales for completion.

The manager told us surveys were sent out annually to people who lived in the home and relatives. We saw a satisfaction summary for 2014 which was based on 18 responses received out of 44 sent out. The summary compared the home with the provider's other care homes and areas for improvement were identified but the report did not show what action had been taken as a result. It was not clear how this information was fed back to people who had participated in the survey.

We saw minutes from the last residents' meeting which was held in October 2014. This showed a number of issues had been raised about the food, delays in being assisted by staff to the toilet and staff not talking to people when they were delivering care just talking to each other. We asked the manager how these issues had been addressed and they said they had been discussed with staff at the daily communication meetings. We saw no evidence of this and no information about residents or relatives meetings displayed in the home.

We saw minutes from staff meetings that had been held in October 2014 and January 2015, which discussed the quality of care.

We saw reports from the previous four months of monitoring visits undertaken by senior managers from the quality and governance teams which identified many of the issues we found at our inspection. We saw actions had been identified with timescales for these to be completed by the registered manager. We saw the previous registered manager had begun a quality assurance audit in November 2014 to follow up on issues identified, however this audit had not been fully completed. The new manager told us they were undertaking a further quality audit the week after our inspection.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the regional director following the inspection who was aware improvements were required at the service and explained there had been delays in implementing the improvement strategy due to changes in leadership at the home. The regional director submitted an action plan following our inspection which showed measures they had put in place to address the issues we had raised at the feedback sessions at the end of the inspection. This showed an accident and incident analysis had been implemented and the manager was submitting weekly reports to confirm actions had been completed which were being checked by unannounced fortnightly visits from the governance team. Meetings had also been held with staff to make sure they were fully informed of the action plan.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet the needs of service users. Regulation 18 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had not protected service users from abuse and improper treatment as systems and processes were not established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation 13 (1) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had not ensured the care and treatment of service users was appropriate, met their needs, and reflected their preferences. Regulation 9 (a) (b) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had not ensured systems or processes were established and operated effectively to**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had not ensured service users were treated with dignity and respect. Regulation 10 (1)
	assess, monitor and improve the quality and safety of the services provided and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17 (2) (a) (b)