Four Seasons (Bamford) Limited

The Albany Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on the 24 July and 9 October 2014. We decided to carry out a second visit as part of this inspection as serious concerns had been raised with us following the first visit. Both visits to the home were unannounced.

The Albany Care home is situated in Headington near Oxford city centre. The home is registered to provide accommodation, nursing and personal care for up to 48 older people.

The registered manager left on the 4 August 2014 and a new manager started working in the home on the 6 August 2014 and had not yet applied to be registered with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

On the first day of the inspection we did not identify any breaches of regulations however we then received information of concern relating to the care and welfare of people living in the home.

Summary of findings

Five registered nurses had left since August 2014. At the time of this inspection agency nurses were being used to cover the shortfall as there were no permanent registered nurses working in the home. The provider had voluntarily agreed not to take on any new admissions until registered nurses had been recruited and improvements have been made to the delivery of care for people.

The provider had reviewed the staffing arrangements since July 2014 to reduce the risks to people due to the lack of permanent registered nurses. There were 29 people in the home some with complex health care needs. The provider had ensured there were two registered agency nurses on duty at all times. The provider had also increased the care staff by one care worker per shift, to assist the agency nurses with getting to know the people living in the home.

People were not always receiving their medicines as prescribed and at the time they needed them. Systems for ordering and checking medicines were not robust. Some medicines were not available and there were some surplus to requirements which had not been destroyed appropriately. The high dependency on agency nurses had a negative impact on how people's health care needs were being met. This included prompt updating of care plans, delivery of care and treatment, safe medicines management and day to day management of the care staff.

People were not always involved in making decisions about their care or treated in a respectful and dignified manner. Staff were not consistent in how they supported and cared for people.

Whilst the majority of the home was clean, well-furnished and free from odour. The treatment room was not clean, was cluttered and there were some risks in relation to the storage of laundry. This meant that not all risks relating to infection control had been reduced.

Staff had received some training in safeguarding, health and safety, moving and handling and keeping people safe. However, staff had not received training in meeting people's individual needs such as dementia, Parkinson's, diabetes or pressure area care. This meant staff were not always aware of how the person's condition could impact on their life. Staff annual appraisals and supervision were not taking place to support good practice as there were no registered nurses employed to take on this responsibility.

There was a lack of leadership for care workers as a result of the absence of permanent registered nurses who could guide and direct them on each shift. The provider had developed an action plan to reduce some of the risks to people and support the care staff. This included ensuring there was senior management presence seven days a week including a clinical facilitator and a peripatetic manager. This had been put in place the week before the inspection carried out on the 9 October 2014 and roles were still being embedded.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not safe. There were not suitable systems to ensure medicines were ordered and given to people safely and when they needed them.

There were sufficient numbers of staff to keep people safe. However, the lack of permanent registered nurses working in the home increased the risks that people's health care needs were not being met. This was because the agency staff were not familiar with people.

Whilst the majority of the home was clean, well-furnished and free from odour. The treatment room was not clean and the organisation's policies were not always followed in respect of the safe handling of laundry.

Staff could identify the signs of potential abuse and knew the correct procedures to follow if they thought someone was being abused.

Is the service effective?

Inadequate

The service was not effective. We found staff were not consistently following the care plans to ensure people's health needs were met. Risks to people were increased as staff did not always know the person well enough to provide consistent treatment that met their needs.

Staff had received some training but training relevant to people's medical conditions, for example dementia, diabetes, Parkinson's and pressure area care had not been completed. This meant staff lacked understanding about how these conditions impacted on the people they were supporting.

People were not always involved in the decisions about their care. Where people lacked capacity decisions were not always made in their best interest.

People enjoyed the meals and had a choice about what and where to eat. However, there was a long gap between tea and breakfast and some people did not receive the support they needed with their diet and nutrition.

Is the service caring?

Requires Improvement

People could not be assured the staff were always caring. Some staff were polite and considered people's dignity whilst other staff showed little regard for the person. This was because they did not always explain to people what they were doing and involve the person in making decisions about their care.

People were not always treated in a dignified and respectful manner that recognised them as an individual.

Summary of findings

Is the service responsive?

Inadequate

People were not always receiving a service that was responsive to their individualised needs. Care plans lacked some key details about how the person wanted to be supported and how their medical condition impacted on their life. This meant care could not be delivered in a personalised way or reviewed when changes had taken place.

Some people's call bells were not within easy reach which meant they could not alert the staff when they needed assistance.

People were supported to take part in a range of activities in the home, which were organised in line with people's preferences. People were supported to receive visitors.

There were mixed views about how concerns were responded to. Some people felt confident that these would be addressed promptly whilst others thought they were not listened to.

Regular meetings had taken place with people and their families so that information could be shared and their concerns listened to.

Is the service well-led?

Inadequate

Effective systems were not in place to ensure the service was well led. Whilst there were systems to check the quality of the service, the action taken to address any shortfalls was not done quickly enough to reduce the risks to people.

The management of the home had recently changed and there was not a registered manager. The provider had organised additional management support to assist in making the necessary improvements. This was because there was a lack of leadership for care staff as there were no permanent registered nurses working in the home to guide them.

The provider was not considering best practice in relation to meeting the care needs of people in personalised and planned way.

The Albany 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 checked 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.

We previously inspected this service in July 2013 and no concerns were raised. This inspection took place on 24 July 2014 and 9 October 2014 and was unannounced. At our first visit we did not identify any concerns however since that visit the local authority raised serious concerns about risks to people following the resignation of the registered manager and employed nurses. The findings of this report refer to day two of the inspection.

The membership of the inspection team included two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our visit we asked for a Provider Information Return (PIR) to be returned to us. The PIR is information given to us by the provider. We reviewed the information included in the PIR along with information we held about the home. This included previous inspection reports, complaints, notifications and information from the local authority. A notification is information about important events which the service is required to send us by law. We also spoke with the local safeguarding team about recent information that they had received from other professionals. This enabled us to ensure we were addressing potential areas of concern.

During the inspection we 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. We spent time observing how staff cared for people over the lunchtime and for a short period in the afternoon.

We spoke with eleven people, four relatives, two registered agency nurses, eight care workers the peripatetic manager, the clinical facilitator and the manager. We looked at five people's care records and records relating to the running of the home. This included the provider's system for monitoring the quality of the service and records relating to staff training and support.

Inadequate

Is the service safe?

Our findings

The service was not safe. Medicines were not managed safely. There were no suitable systems to ensure medicines were ordered and given to people safely and when they needed them. There were no systems to check on the amount of medicines held in the home which resulted in medicines not being available or being surplus to requirements. Those medicines that were surplus to requirements had not been disposed of appropriately. This included controlled medicines which are required to be stored and handled in a specific way.

People told us they did not get their medicines on time or when they did get them they were not as prescribed. One person told us that their medicines had not been given on time in the morning and this impacted on their medical condition and on their medicines throughout the day. They also told us that on the day of our inspection, when it came to lunchtime they had only been given one tablet instead of two. The registered nurse then returned an hour later with the second tablet. They also told us their prescribed pain relief had not been available the night before. We looked at the medicine record for this person and checked what stock was available. The system was confusing as the same medicine was in a both a blister pack and in a bottle. This was not clear for the registered nurses that administer the medicines. The medicine record for lunchtime had been signed but it was not clear that one tablet had been given an hour later. There was no stock record of the pain relief to ascertain if this had been available for the previous night. A new supply had been delivered on the day of our visit. Medicines received from the pharmacist had not been recorded on the medication administration record.

A relative told us they had also raised concerns with the manager about how medicines were often not given at the correct time or were not available. An agency nurse told us there had been a delay in giving medicines to four people as these medicines had not been available on the morning of our inspection. We were told there had been a delay in the pharmacy delivering the medicines as it was the first day of the months supply. The manager told us some medicines had been delivered the day before our inspection but some medicines were missing. Staff were still checking the medicines during the afternoon, when these should have been available to give to people that morning. The lack of organisation in ensuring medicines were available was having a serious impact on the people as they were not receiving their prescribed medicines at the time they needed them.

There was a risk that people did not receive some medicines safely. We saw a small medicines pot with opened medicines capsules on top of the trolley. We also saw a tablet crushing device on the trolley. We asked the agency registered nurse about this. They said some of the people were tube fed and they had been given instructions to do this. We looked in the medicines administration policy. We saw the medicines policy had information on medicines administration for people who were being supported with their nutrition by tube feeding systems. There was no general policy on the crushing of medication and the actions registered nurses needed to do, to ensure this took place in a safe way and maintain the stability of the drug.

The arrangements for the administration of medicines on an “as required basis” (PRN) did not protect people from inappropriate use of or unsafe use of these medicines. There were no instructions for the registered nurses to follow to decide if a person needed the PRN medicine they were prescribed. The provider’s medication policy stated ‘where people were prescribed PRN medication, there must be clear instructions for registered nurses’. This was to inform them of relevant factors, including the indicators of use of such medication for each individual. The provider’s clinical facilitator confirmed no such information was available in the home. We discussed PRN medication with one of the agency registered nurses. They reported they used their clinical judgement about when to administer such medicine. They agreed this could be complex, as they did not know individual people or their needs as they had not worked regularly in the home. Some of the people living in the home had difficulties with communication and would be unable to tell them that they required their PRN medication. As there were no plans about the use of such medicines, they would not be in a position to advise people’s GPs as to the effectiveness of such treatment for the person.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 management of medicines. You can see what action we told the provider to take at the back of this report.

Inadequate

Is the service safe?

Five registered nurses had left the employment of The Albany over the last three months. Risks to people had been increased as the home was being staffed by agency nurses. This was because the agency nurses had not worked in the home regularly, therefore did not know the people or the systems that was in place to meet their health care needs. The two registered nurses on duty at the time of the inspection had previously only worked one shift. The manager told us they were trying to cover with regular named agency staff to reduce some of these risks. In addition, they had increased the staffing numbers to ensure there were two registered nurses working in the home at all times.

Staffing levels had been reviewed using the organisation's dependency tool on the 30 September 2014. An additional care assistant was working on each shift to support the agency staff when giving medicines. This was because some of the agency staff would not know the people in the home. However, we observed the agency nurses were not supported by a care assistant when completing the medicines round in the morning and at lunchtime.

Duty rotas confirmed that there were nine care assistants in the morning, seven in the afternoon and three care staff working at night. We saw that there were two registered nurses working at all times. People raised concerns about the high usage of agency nurses as they felt they did not know them well enough. However, two relatives and a person commented positively on the recent changes in staffing confirming there had been additional staff recently.

Whilst we found the majority of the home was clean, comfortable and well furnished when we went into the treatment room where the medicines were stored, we found the area was not clean. There were cobwebs on the ceiling and the walls. There was plaster missing from the wall and it was cluttered, making it difficult to clean thoroughly. In addition there was no sink for the nurses to wash their hands. The nearest sink was a bathroom along the corridor that was used by people living in the home. The treatment room was used to prepare medicines such as injections. Drawing up injections in an unclean area could present a risk of infection to people. Domestic staff told us the cleaning of the treatment room was the responsibility of the registered nurses. The high usage of agency nurses had meant that no one was taking responsibility for this area.

A trolley containing clean towels and bedding also contained a laundry bag for dirty items. There was a risk that the clean laundry could be contaminated by the dirty laundry. The laundry bags were not colour coded enabling heavily soiled laundry to be kept separate from other items. The bag was removed after we brought it to the attention of staff. However we saw it had been replaced during the afternoon. When we pointed it out to the laundry worker, they made sure it was removed again. This indicated not all staff were aware of principals of prevention of spread of infection when managing clean and used laundry. The infection control policy confirmed that coloured laundry bags should have been in place. The manager told us they had ordered new laundry skips and was addressing this area.

These incidents were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 cleanliness and infection control. You can see what action we told the provider to take at the back of this report.

The manager was able to explain to us how they would respond to allegations of abuse and this was in line with the local authority agreement on safeguarding vulnerable adults. The safeguarding policy was displayed in the nurses' office and was available to both nurses and care staff. The majority of the care staff had received training in safeguarding. Staff were confident about how to recognise and report concerns of potential abuse and told us they would report this to the nurse in charge or the manager.

We saw evidence that the manager had notified the local authority, and us, of some recent safeguarding incidents as required. The provider was working with the local authority to provide assurances that people were safe and safeguards were in place in respect of these recent alerts. As part of these safeguarding incidents the provider has agreed not to admit any new person to the service for the time being. This was to ensure people were safe and improvements could be sustained with the recruitment of permanent nurses.

Recruitment practices protected people from unsuitable staff being employed. The manager told us they had recruited five registered nurses and were waiting for their checks to be completed in respect of the Disclosure and Barring Service (DBS) and references. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and

Inadequate

Is the service safe?

whether they were barred from working with vulnerable adults. The manager was able to describe to us that a safe recruitment process was being completed before new staff started working. We were told that it would take up to four to six weeks before the registered nurses were working in the home.

Inadequate

Is the service effective?

Our findings

Concerns had been raised with us about the care and welfare of the people living in The Albany. The concerns had been raised by relatives and the safeguarding team. This was because there were no permanent nurses employed in the home and they were reliant on agency nurses. Risks to be people had increased as staff did not always know the person sufficiently or have access to clear records to enable them to provide consistent, effective treatment, for example with monitoring wound care, diabetes and use of specialist equipment. A few people had been admitted to hospital as these conditions had not been monitored to ensure that prompt action was taken to reduce any further complications.

Care records provided some information for the nursing and care staff to follow, these covered personal care, health care, social occupation, support with moving and handling and nutrition. These had been kept under review on a monthly basis by the agency nurses and care staff. Some updates to care plans had been documented in the daily notes rather than updating the care plan. There was therefore a risk staff would have missed important information, for example, an instruction for a person's equipment to be checked every two hours as previous risks had been identified. When we asked staff where this was recorded there was no record. This meant this person was still at risk of not receiving effective treatment for their condition as the checks were not in place.

We had been informed by external agencies that there had been concerns identified relating to people sustaining pressure wounds. Care workers told us they had not received training on pressure wound prevention. They said they provided care to people at risk based on what they had been told by other staff during the course of their duties.

People were not receiving care that ensured their needs were met. Three of the people we met with were assessed as being at high risk of pressure wounds. One of these people had a major pressure wound, which we were told had been sustained prior to their admission to the home, some time ago. They had a care plan in place which stated they were to be supported to move their position every three to four hours. We looked at their records and saw this was not taking place. For example on 6 October 2014, their records showed they remained in the same position for a period of nearly 11 hours. On 7 and 8 October 2014, their records showed they remained in the same position for a period of just under 15 hours. The person was sat in a chair during the afternoon of our inspection. A care worker told us they were on an electrically operated air cushion and they did not need to have their position moved when they were sitting out in the chair. A person's risk of pressure wounds does not reduce when they are using an air cushion and position changes are also required to prevent skin damage. The person's care plan did not note actions to be taken to reduce the person's risk when they were sitting in a chair.

We looked at the two other people's care plans and records. These care plans did not describe how often they were to be supported to have their position changed. Daily records did not show their position was changed regularly to reduce the risk of pressure wounds. Two care workers told us one of the people could change their own position on their own, but needed reminding to do so. They told us the other person tended to roll back on to their back once their position had been changed. This information was not documented in the people's care plans on how to reduce these risks.

Two of these people had their sheets tucked in over their air mattresses. Manufacturers' instructions for air mattresses state tucked in sheets can impair their effectiveness and sheets need to be placed loosely over the mattress to ensure the risk was reduced. Two of the three people did not have instructions or records relating to their air mattresses including individual setting relating to their weight.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services. You can see what action we told the provider to take at the back of this report.

People were registered with a GP. People confirmed they could see their GP when required. The manager told us the people had access to seven GP surgeries in the local area. They told us this had added to the difficulties they were experiencing with the ordering of medicines. We were told this was being reviewed so that ordering of the medicines could be simplified. This may mean some people changing their GP. Other health care professionals were contacted as and when required. Care documentation included information about the appointments and the outcome.

Inadequate

Is the service effective?

Care staff told us they had not received training in the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. Care workers told us it was the responsibility of the registered nurses to complete the mental capacity assessments. They also organised best interest meetings where people lacked the mental capacity with family and other health care professionals. There were no permanent registered nurses to complete the mental capacity assessments.

People's rights were not protected in accordance with the MCA. People's care records included information about how they were involved in making day to day decisions. Care records included an assessment of a person's mental capacity. However, these assessments were not always current or being followed. For example, one person had been assessed as having capacity but their relative had made important decisions including consent to taking photographs, end of life care and the use of bed rails. Staff told us it was difficult to understand this person however there was no guidance in the plan of care how they could facilitate better communication to enable them to be involved in decisions. We met with another person and it was evident they had difficulty in retaining information. This was confirmed with staff. However, the mental capacity assessment did not capture this. Staff told us they were making decisions on behalf of this person on a day to day basis including whether the person should remain in bed all day.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment. You can see what action we told the provider to take at the back of this report.

The service was complying with the legal requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. The manager told us they were reviewing everyone in the home and so far one application had been made in respect of a DoLS. They were waiting for an MCA assessor to meet with them and the individual. The manager was aware of the recent changes to the thresholds of making DoLS applications.

People we spoke with gave us very positive comments about the meals. One person told us; "the foods very good, it suits me" another person said "the food is fantastic" and another person said "you cannot fault the food, however the portions are far too big." The meals both looked and smelled appetising and were attractively presented. However, we observed that the lunch finished at 13.15 and the evening meal started at 16:00. We asked staff if a supper was served later in the evening. They told us drinks and biscuits were provided at about 20:00. This meant people had most of their nutrition provided within the space of four hours, with only snacks provided for a further 13 hours, until breakfast started.

When we visited one person at midday, we saw they were in bed. There was about half a cup of tea which was cold and a piece of toast which was stale and two biscuits on a surface across the room from the person. The person had not been left with any other drinks to hand. The person told us; "a cup of tea would be nice". Care staff told us the person was very reluctant to eat, although they liked biscuits and loved tea. There was no information in the care plan to guide staff on how they could encourage this person to eat. This person had not been weighed since August 2014 which meant they could not review the person's weight loss or gain. Another person had two bowls of uneaten porridge, which they told us they did not like. The daily food chart had already been completed and indicated that this person had eaten the porridge. This meant staff had completed the record prior to the food being consumed. It would be difficult to monitor the food and fluid intake for this person as the records were incorrect, therefore putting this person at risk of malnutrition.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 meeting nutritional needs. You can see what action we told the provider to take at the back of this report.

Staff told us they had received moving and handling, health and safety, safeguarding adults, dealing with conflict and fire training. Staff told us they had not completed training relevant to the care needs of the people including supporting people with Parkinson's, pressure wound prevention, dementia, diabetes and other health conditions. Staff were unable to describe to us how these conditions impacted on people living in the home. A care worker told us that training on dementia was being organised and a date set in November 2014. A senior manager told us an action plan was being developed for

Inadequate

Is the service effective?

the training needs of staff. Some training had been given to the agency nurses in supporting people with diabetes and specific equipment in the home. Although the two agency staff on duty had not received this training from the provider.

We spoke with staff about the support that was in place including one to one supervision meetings with manager. They told us one to one supervisions had not taken place at regular intervals since the manager left in August 2014. We looked at the supervision record for all staff and it showed there were gaps where staff had not received any formal supervision since January 2014. We saw this had been an area that had been identified for improvement in the provider monthly visits in June, July and August 2014.

These were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting workers. You can see what action we told the provider to take at the back of this report.

The agency registered nurses told us they had received a comprehensive induction on their first shift. Daily support was available from the peripatetic manager and clinical facilitator who were both registered nurses. Shift planners had been developed which gave a brief overview of each person's personal and health care needs so the staff could check what they had to do to support people. This information included information about any special diets, likes and dislikes and the person's medical condition.

Requires Improvement

Is the service caring?

Our findings

Whilst we observed some people being supported in a caring manner this was not consistent. Comments from people were generally positive about the care staff that supported them. Comments included; "you cannot fault the care staff they give 100%, however, it will be better when there are nurses in the home", and another person said; "the activities are very good, (named staff) makes it fun, and x is an angel with wings". Some people told us how supportive and kind the staff were to them. Another person told us how supportive staff had been when they were unwell. However, some people were not so positive. Comments included; "Staff are alright but I really only see them when they do things for me" and another person told us; "I'm not that happy at the moment I'm still waiting to be hoisted so I can go to my room. The staff are caring but some of them don't know what my needs are and when they hoist me they sometimes use the wrong straps and that can be painful".

People were not always treated with respect. We observed a care worker who was supporting a person who was living with dementia, they did not use the person's name at all throughout the time they were supporting them. They addressed the person as "dear". We also observed a senior manager addressing people using the term "darling," not their name. There was no information in care plans on how people would like to be addressed or whether they liked these terms of endearment.

One person told us; "The care has got worse, I had to wait for two hours for a drink of water, and I asked a care worker several times before I got it. I don't like the agency staff they take the fun out of me. People don't talk to me because of my disability as it takes me time to talk". When we checked this person's care plan and spoke with staff it was evident there was no information to guide staff on how they could communicate with this person. The person told us it was frustrating as not all staff understood them.

Some care workers were not caring in their approach to people. We observed a care worker supporting a person with their lunchtime meal, they did not engage with the person at all apart from the function they were performing. Another care worker moved a person in a wheel chair without telling them they were going to do this or asking their permission. A third care worker removed a clothes protector from a person, without asking their permission or informing the person this was what they were going to do. This care worker also supported a person to have a drink from a beaker; there was no communication between them and the person during this activity. The care worker only occasionally looked at the person while they supported them. A person told us; "some staff do not tell me what they are going to do, they just do it".

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use the service. You can see what action we told the provider to take at the back of this report.

Other staff were caring in their approach to people. We observed staff promptly and politely supporting a person who was in bed whose covers had fallen off to make them more comfortable. They gently went into the person's room and supported them by replacing some of their covers, so their privacy and dignity was protected.

Over the lunch time period we observed some staff were very caring in their approach to people. One of the care workers sat with a person who needed support. They made the meal a social occasion for them, supporting them with eating and engaging them in general conversation. The care worker clearly knew the person they were supporting, including details about their past life, which they brought up in conversation with them. The assistance given to the person was unrushed and was at an appropriate pace.

We observed a member of the catering team discussing with people what they thought about the meal. They listened to what people said in an approachable and open manner. We also observed the maintenance worker going through the area. They took the time to smile and engage with people. One person was observed enjoying this healthy banter.

Visitors told us they could visit the home whenever they wanted and they could meet with their relative in private if they wanted. We observed some visitors taken part in the activities that were going on and being offered refreshments.

People we spoke with had mixed views on their involvement in decisions about their care. One person told us they meet with staff regularly to discuss their care plan and support. Whilst other people were not aware they had a care plan and told us they had not been asked how they

Requires Improvement

Is the service caring?

would like to be supported. Another person told us "the staff are really good they ask me regularly how I would like to be supported, I have a bath every day because of my condition and this is accommodated".

We observed the agency nurses administer medicines. They supported people in a kindly way. For example we saw one of the registered nurses helping a person who had complex needs. They did not rush the person, giving them their tablets slowly, offering drinks in between each tablet and encouraging the person throughout the time they were helping them.

Inadequate

Is the service responsive?

Our findings

People were not always receiving a service that was responsive to their individualised needs. Some people we met with could not reach their call bells. One person's call bell was tucked under their mattress on four different occasions when we saw them. The person showed us how they contacted the staff by banging the bedside table with their glasses case to summon assistance. When we used the call bell on this person's behalf, there was no response from staff for seven minutes. A member of staff that was passing the bedroom door was asked to assist the person. The member of staff went to find the member of staff allocated to the area of the home where the person was. This meant the person had to wait again before their request for assistance was responded to.

Another person told us staff responded to them quickly if they used their call bell. They told us the systems used by the home did not always work. They reported they had told the previous manager about this but nothing had happened to improve the situation. They reported the new manager had listened when they told them about the issue and they were confident action would now be taken. We asked the manager how they monitored response times to call bells to check if people were attended to promptly. They told us there was no formal monitoring system in the home.

We met with a person who had complex needs relating to their diabetes. They told us some of their symptoms when they were unstable. Two care workers also described the symptoms. This was not documented in the person's care plan, so new staff may not be able to respond to prevent further changes in the person's medical condition. There were limited records of site rotation of the injection sites. This was a risk as the registered nurses could not respond to the person's needs and prevent over-use of the injection site. This could lead to instability of the person's diabetes as the uptake of insulin may not take place effectively.

We spoke with an agency nurse who told us about a medical emergency they were responding to during the morning. It was evident they had taken appropriate action including making contact with a diabetes specialist for advice. Information had been verbally communicated during the morning handover but this had not been recorded in the person's care records. The record of the person's blood sugar was not being completed consistently and there were gaps. The lack of recording of the person's condition meant this could not be monitored to ensure the person remained stable. Staff were not following the advice of the diabetes specialist to ensure the person's changes in their diabetic condition were effectively responded to.

We observed staff supporting a person with dementia. This person was anxious as they thought they had lost their purse. Staff responded by telling the person they had already answered and responded to this earlier. This showed no understanding of the person's dementia. Staff told us they had not received training in supporting people with dementia. The care plan for this person did not describe how their dementia affected them or give guidance on how to support their specific needs. The care plan stated the person was at risk of social isolation. Staff told us the person stayed in their bedroom the majority of the time. There was no guidance for staff on how to minimise the risk of isolation.

These were breaches of Regulation 9 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare and records. You can see what action we told the provider to take at the back of this report.

Activities were being organised for people including skittles, board games and bingo. People told us when the activity co-ordinator was working there was regular activities taken place. A relative told us mini bus trips to places of interest were organised but these had not taken place recently. We discussed this with a member of staff who told us this was because there was a lack of drivers available to drive the home's minibus but the manager was addressing this area. Care plans included information about people's interests and histories. The activity co-ordinator told us this information was used to plan activities either in small groups or on a one to one basis.

Visitors told us they could visit the home to spend time with their relatives whenever they wanted. They told us they could meet with their relative in private and join in the activities of the home. There were comfortable seating areas for people to sit with each other or their visitors in the lounges and corridors. Alternatively people could receive visitors in their bedrooms.

Most of the people we spoke with confirmed they felt confident in raising concerns with the manager. One person said; "I'm sure if I complained I would be treated seriously"

Inadequate

Is the service responsive?

and another person told us; “If I had a complaint I would speak to the manager. She often comes and sees me for a chat to make sure everything is ok. She also asks about the care I receive and if I’m happy with that. I feel listened to and staff respond with kindness and consideration”.

Some relatives told us they had met with the manager to discuss some of their concerns in respect of the high use of agency staff and medicine management and these were being responded to. One person told us; “I complained about a fixture and fitting that was not suitable in my room to the last manager, nothing was done but I have not mentioned this to the new manager”. This was addressed during our inspection when we raised the concern with the manager. Another person told us they did not feel as though they were listened to and errors were still being made with their medicines despite raising this with the manager.

Since August 2014 regular house meetings had taken place with relatives and people to listen to their views. The topics of conversations had included staffing, medicine management, call bells, emergency contacts, activities, menu planning and concerns about care. The minutes included any follow up information and actions taken since the last meeting. An example of this was where the menu board had been moved from the entrance hall to the dining area as people said this would be a better position. Relatives confirmed their attendance telling us they found it useful to keep up to date with the changes.

Inadequate

Is the service well-led?

Our findings

Since the inspection in July 2014 the manager left the service along with five registered nurses. This has had an impact on the way the service was managed. This has impacted on the delivery of nursing care and the day to day management of the care staff. A new manager was appointed in August 2014. However, recruitment for the registered nurses was still on-going. This was because they were waiting for references and criminal record checks to be returned.

The regional manager completed monthly visits to the service on behalf of the provider. This enabled the provider to monitor the quality of the service. Records were maintained of these visits. The medicine management was reviewed in July 2014 by the regional manager. There were concerns raised about the amount of stock in the home and the storage of medicines. It was also noted there were no protocols for as and when required medicines (PRN). The report of the visit in August 2014 stated that an urgent review of medicines and storage was required. The visit completed in September 2014 stated an audit was still required. Whilst the visits had identified this as an area of concern and risk there was no evidence any action had been taken until the end of September 2014. Some of these concerns had not been rectified at the time of our inspection. This meant people were not protected people against the risks associated with unsafe use and management of medicines. The visit in August and September 2014 both highlighted quality checks had not been completed by the manager on nutrition, care planning and bedrails. It had also been noted that since June 2014 one to one supervisions had not taken place with staff. This showed us that quality assurance systems were not robust and required improvement to ensure risks were identified and quickly rectified.

This was a breach Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring of the quality of service provision. You can see what action we told the provider to take at the back of this report.

Staff told us that the running of the home had improved and the new manager was approachable and worked alongside them. The manager told us they were committed to making improvements, including recruiting registered nurses and building a team. Regular meetings had taken place since August 2014 with people and their relatives and the staff team. People had been kept informed about the changes in the staffing and the appointment of the registered nurses.

The manager understood the challenges the home faced and had plans in place to improve the quality of the service especially in relation to ensuring people's health and nursing care needs were being met. The manager was not a registered nurse and was being supported by a peripatetic manager and two clinical facilitators that worked for the provider. They were registered nurses and were supporting the staff and the manager seven days a week. We saw the rota that confirmed this cover was in place. Part of their role was to support the manager in driving improvements in the home. This included auditing the medicines on a daily basis and putting in systems to improve ordering, stock control and storage. An action plan was in place detailing the action that was required, who was responsible and timescales. Audits were now starting to be completed including an audit of care plan documentation and people's weights. The clinical facilitator told us where people had lost weight appropriate action had been taken by the care staff and a care plan was in place.

The manager told us they organised daily meetings with the senior care staff, head of housekeeping and the registered nurses to discuss any concerns enabling them to plan the shift and minimise risks.

Although staff told us they felt supported by the management team, we found that there were no systems in place to ensure that staff were able to carry out their role and responsibilities safely and effectively. This included regular one to one supervisions and appraisals to look at the member of staff's team training needs and that of the staff team. In addition there was a lack of guidance and support in relation to best practice when supporting people with known conditions for example dementia ensuring this was person centred and planned.

We discussed the roles of staff in the home, care staff told us there was no key worker system in operation and no dignity or dementia champions. Key workers are a named member of staff who is responsible for the welfare of one or more people enabling them to build a relationship with a person living in the home. Staff told us they were not assigned to a specific area on a regular basis and could work with people either on the ground or second floor.

Inadequate

Is the service well-led?

We asked how effective relationships could be built when there was no continuity for people. Staff told this could be difficult but during the day most of the staff were expected to work downstairs in the communal areas. Staff told us; "we just get on with our work and support everyone". There was no clear leadership for the care staff due to their being no permanent registered nurses working in the home. Whilst care workers told us the agency nurses were generally good, they acknowledged the agency nurses did not know the people living in the home and relied on them for information about people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **How the regulation was not being met: People who use services and others were not protected against the risks associated with infection control as not all parts of the home were clean and arrangements were not suitable in respect of managing laundry to prevent the risks of infection. Regulation 12 (1) (a) (b) (c) (2) (a) (b) (c) (i) (II) (iii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **How the regulation was not being met: People who use the service were at risk of unsafe or inappropriate care and treatment as their records were not current and did not reflect the care that was being given. Regulation 20 (1) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **How the regulation was not being met: People were not being supported by staff that had received appropriate training relevant to their health care needs or received supervision and an annual appraisal. Regulation 23 (1) (a) (b) (2) (3) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: People were not being treated in a dignified and respectful manner. Regulation 17 (1) (a) (b) (c) (2) (a) (b) (c) (ii) (d) (e) (f) (g) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: Quality assurance systems were not robust and required improvement to ensure risks were identified and quickly rectified. Regulation 10 (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: People were not protected against the risks of inadequate nutrition and dehydration. Regulation 14 (1), (a) (c)

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 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The provider was not protecting people against the risks associated with the unsafe use and management of medicines, there were no appropriate arrangements for the safekeeping, dispensing, safe administration and disposal of medicines. People were not receiving their medicines in a timely manner. There was no clear directions for as and when required medicines. There were no safe systems for the storage and disposal of medications, including controlled drugs. There were no safe systems in place in relation to the crushing of medication or opening of capsules of medication.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The provider was not taking proper steps to ensure each person was protected against the risks of receiving care or treatment which was inappropriate or unsafe. This was because some people did not have a full assessment of their needs. The planning and delivery of care and treatment did not consistently meet the person's individual needs and ensure their welfare and safety. Planning and delivery of care also did not reflect published guidance from professional and expert bodies as to good practice in relation to their care and treatment.