Care UK Community Partnerships Ltd

Farm Lane

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 November, and 8 December 2015. The inspection was unannounced on the first day and we informed the provider we were returning on the other two days. At the last inspection in July 2014 we found the provider was meeting the regulations we looked at.

Farm Lane provides accommodation for up to 66 people on three separate units. This includes 21 rehabilitation beds, managed in conjunction with Central London Community Health Care NHS Trust. The nursing and care staff are provided by Care UK Community Partnerships Limited and the specialist team of physiotherapists, occupational therapists and speech and language therapists are employed by the NHS. The remaining 45 beds are used to provide nursing care for older people with healthcare needs due to physical frailty and older people living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We found that there were not enough staff deployed at all times to safely meet people's needs. The recruitment of staff was not consistently thorough in order to robustly ensure that people were cared for by staff with appropriate skills and knowledge for their roles.

Although nursing staff received medicines training and there were systems in place to monitor the management of medicines, we found issues of concern about specific aspects of the medicines service.

People told us they felt safe with staff, who had received safeguarding training and understood how to protect people from abuse.

Risk assessments were conducted as required and people were routinely assessed to identify their potential risk of health care problems associated with the ageing process and frailty, for example risk of skin damage, falls, malnutrition and hydration.

The premises were safely and hygienically maintained in order to provide people with a comfortable environment.

People and their relatives predominantly told us they thought staff had the appropriate expertise to provide the care they needed. However, this did not match information we had received from people and relatives prior to the inspection, who expressed concerns about the skills and approach of the staff team. Records demonstrated that staff received training, supervision and appraisals in order to improve on and monitor their knowledge and performance.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on our findings. DoLS are in place to protect people where they do not have the capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others. Although staff had received applicable training, some did not understand the principles of the Act.

A varied and balanced diet was provided, although some people indicated areas of the food service that could be improved upon. We observed people being supported with meals and drinks in a patient and respectful manner.

People were able to access health care support from doctors and other health care professionals, including dietitians and community specialist nurses. However, the registered manager and people who used the service told us there were delays in accessing NHS podiatrists, so people sought private services instead.

There were some conflicting views expressed about whether staff were kind and caring, and our own observations indicated that some staff did demonstrate their fondness for people during interactions but were often task orientated due to the busy level of work.

Records relating to how people were supported with their personal care were often confusing due to the provider using a combination of hard copy and electronic records. This meant that sometimes important documents such as moving and positioning charts were not properly completed but other information to demonstrate that people were provided with this care was recorded on the electronic care plans.

There was a programme of activities and entertainment provided by the activities team. However, some people reported that they were bored at times and needed more stimulation. We observed that people sat in their bedrooms and in lounges for lengthy periods watching television.

People and their relatives were provided with information about how to make a complaint. All complaints were investigated; however, the quality of some of the investigations was not satisfactory and within given timescales. The provider did not demonstrate how they used complaints as a learning tool for service improvement.

There were quality assurance systems in place to monitor the quality of the service and seek the views of people who used the service, relatives and staff. However, we found that the systems used by the provider had not identified and addressed the range of problems that we found during the inspection.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe staffing levels, rigorous recruitment, safe management of medicines, record keeping for person centred care that reflected people's accurate needs and wishes, complaints investigations and quality monitoring.

You can see what action we told the provider to take at the end of the main report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Insufficient staff were deployed to ensure people's safety and staff recruitment was not robust enough to ensure staff were suitable to work with people using the service.

People's medicines were not always managed appropriately.

The premises were clean and equipment was safely maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training and support to carry out their roles.

Although there was evidence of people being referred for Deprivation of Liberty Safeguards and staff understood the need to ask people for their consent, some staff were not clear about the principles of the Mental Capacity Act (MCA) 2005.

People received a varied and balanced diet, which included diets to meet cultural and specific medical needs.

The service referred people for health care support from external doctors and health care practitioners, although there were reported delays for accessing NHS podiatry.

Is the service caring?

Requires Improvement

The service was not always caring.

There were varied opinions expressed about the attitude and manner of staff, although the majority of people and their relatives that we spoke with during the inspection stated they liked the staff and found them caring.

We noted that people were consulted about some aspects of their daily lives and their views were respected.

People were invited to attend 'residents meetings' to contribute

to the running of the service and information was provided about advocacy services.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff demonstrated their knowledge about people's needs and wishes, but the care plans did not always have sufficient information to guide staff.

The care plans demonstrated some strength; however, the haphazard use of hard copy and electronic recording meant that some information could not be easily sourced.

People had information to help them make a complaint. The recording of complaints investigations was sometimes incomplete and some complaints were not investigated and concluded to an acceptable standard.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Most people and the majority of the staff we spoke with found the management team were approachable and helpful. We observed that staff were provided with good clinical leadership.

There were systems employed to monitor the quality of the service, but they had not effectively identified concerns which impacted on the quality of care that people received.

Farm Lane

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 2008.

This inspection was unannounced and took place on 26 November 2015 and we informed the provider that we were returning on two further dates, 27 November and 8 December 2015. The inspection was conducted by four adult social care inspectors, a pharmacist inspector, a specialist professional advisor in nursing and two experts 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. One of our experts by experience attended on 26 November 2015 and the other attended on 27 November 2015.

Prior to the inspection we looked at the information the Care Quality Commission (CQC) holds about the service. This included notifications reported to CQC and the last inspection report of 22 and 26 July 2014, which showed the service was meeting all regulations covered during the inspection. We also looked at a Provider Information Return (PIR), which we asked the provider to send to us before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

At the time of this inspection there were 63 people living at Farm Lane. We spoke with 15 people who used the service, eight relatives, 16 members of staff, the lead clinical nurse and the registered manager. During this inspection we conducted observations using the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experiences of people living with dementia who were not able to fully share their views with us.

We looked at records and documents that related to people's care, and the management of the service. This included seven people's care files, staff recruitment and training records, medicine administration records, policies and procedures, and quality assurance audits. Prior to the inspection we spoke with the local safeguarding team and health and social care professionals from the local authority. After the inspection we received feedback from three health and social care professionals.

Inadequate

Is the service safe?

Our findings

Prior to the inspection, we received information of concern about insufficient staffing and how it adversely impacted on the quality of care people received. These concerns were expressed by people who used the service, their relatives, and health and social care professionals who were familiar with the service. During the inspection we received several comments from people and relatives about the staffing levels which included, "They are short of staff especially at the weekend" and "The home is understaffed." A relative told us, "I don't feel he/she would get their medicines, or washed until very late if I wasn't here. There are two young girls to look after 16 or 17 people and they do the kitchen work too. The staff can't cope." A person using the service said, "They're a bit short staffed at the moment, at dinner staff are rushing, only two staff to attend to all our needs" and another person remarked, "Carers' are good here, but they've cut down on them and they work them too hard. If they could get more carers I'd be delighted."

Three members of the care staff told us that staff numbers allocated to each unit were sufficient to meet people's needs most of the time and said that additional staff could be drawn from other units if there were shortages. However, a registered nurse stated that there were not always enough staff allocated to realistically meet people's needs and that there were often shortages if staff telephoned before their shift to report they were not well enough to work. On the first day of our inspection we noted that the first floor unit had one registered nurse and four health care assistants on duty to meet the needs of 20 people, which included 15 people who required varying levels of care and support due to immobility or having problems associated with decreased mobility. On the second day of the inspection we observed that there was one registered nurse and four health care assistants on the second floor unit to meet the needs of 26 people living with dementia; however, a staff member told us that there were often three health care assistants rather than four. We were informed that 20 people required varying levels of care and support because of their immobility or reduced mobility.

Our observations indicated that there did not appear to be sufficient staff to meet the needs of people living at the home. About half of the people remained in their bedrooms on the first floor and staff were often not visible on the floor to attend to people or check on them. The bedrooms were situated along lengthy corridors and staff confirmed that the layout of the premises made it difficult for them to hear people if they called out for assistance. Some people's care plans recorded that they were not able to summon assistance using the call bell system and/or were unable to call out verbally, hence staffing levels and deployment should take this into account.

There were three activities coordinators (equivalent to two full time staff) employed at the service, although only one was on duty on the first day of the inspection. Staff told us that most group activities took place on the second floor unit so people on other floors had to be transferred up to this unit for activities. Staff were observed to be task focused rather than spending time engaging in conversation with people and most interaction appeared to be limited to meal times or when staff were delivering personal care. Staff said that in practice there was little interaction with people in their bedrooms as neither the activities coordinators nor health care staff had time to spend with people for one-to-one chats or social pursuits such as reading a newspaper together. This resulted in some people being isolated in their bedrooms and also in communal

areas for long periods of time, unless they received external visitors.

The registered manager and the lead clinical nurse told us there were occasions that staff were unable to work due to sickness and attempts to replace them were unsuccessful. A staffing dependency tool was used in order to calculate staffing numbers and the management team stated that they closely examined whether staffing numbers and/or the staffing skill mix needed to be changed. The provider did not have a system to electronically record how long people waited for their call bell to be answered, although the management team reported that they conducted daily monitoring when they spent time on the units which included checking that people were responded to in a timely manner.

One person told us they rang the call bell when they knew they needed to use the toilet but were unable to hold on long enough for a staff member to answer, which meant they had episodes of incontinence. The person was provided with incontinence pads but was distressed about the loss of their independence and dignity. The person had a sore sacrum and a positioning programme had been established, which stated that they should be turned every four hours. They had also been prescribed a topical cream for application to the sacrum, which had not yet arrived. We noted that in accordance with the daily positioning chart the person had been placed on their back at 6am on the first day of the inspection and we found that they were still positioned on their back at 12pm. On the second day of the inspection we found that no turns had been recorded on the previous day's chart since 6pm and a new chart had not been commenced. A registered nurse showed us an entry on the electronic care planning system that stated the person had been turned frequently overnight and stated that charts were often filled in retrospectively due to staff being too busy and the health care assistant allocated to the person made personal notes to transfer to the chart when they had the time. This showed that insufficient staffing negatively affected the quality of people's care, and impacted on the safe completion of records required to demonstrate that care was being delivered in accordance to people's identified healthcare needs.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at 10 staff recruitment files in order to check whether the provider adhered to safe recruitment practices. During the past 12 months the provider had appointed 20 new staff and all of the files we looked at were for recently employed staff, including registered nurses, health care assistants and housekeeping staff. The provider demonstrated that staff completed application forms, and provided proof of identity and proof of eligibility to work in the UK. Evidence of valid registration with the Nursing and Midwifery Council (NMC) for staff employed as practising nurses and Disclosure and Barring Service (DBS) checks for all staff was held separately by the management team. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions. However, we found that some of the recruitment appeared disorganised and did not demonstrate a rigorous approach. For example, some interview records and assessment sheets contained limited information to demonstrate why the candidate was suitable for appointment and these records were missing in one file. One employee was given a low rating for their knowledge, skills and experience within health and social care but their file did not contain any explanatory notes to demonstrate why this was not regarded as an obstacle for appointment. In one file, we noted that an employee had a photocopied reference and a second reference in another language without an accompanying translation. Following the inspection, the provider informed us that all references from abroad were checked and acknowledged that this was not evidenced in the recruitment file. We could not find the new application form for an employee who had previously worked for the provider in a different occupational role and two references in another file had not been verified in order to ascertain their validity. These findings showed that appropriate measures were not consistently used to protect people from the risks of unsafe recruitment.

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely including controlled drugs which were recorded appropriately. The fridge and room temperatures were monitored daily and were in range. Medicines received from the supplying pharmacy were recorded in the medication administration record (MAR) charts and the quantities we checked reconciled with the MAR charts. There were medicine plans in place for medicines which were prescribed to be given only when needed, in order to support nursing staff to safely administer. Evidence of site rotation for medicines supplied in patches was seen. A Clinical Commissioning Group (CCG) pharmacist supported the service and conducted regular medicines reviews for people residing on the second floor unit, which provided care and support for people living with dementia. (CCG's are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England). There was also evidence that the GPs reviewed people's medicines during their twice weekly visits to the service.

The ground floor rehabilitation unit was run in partnership with Central London Community Healthcare NHS Trust. Nursing staff told us that they assessed people's needs and suitability for admission to the unit prior to discharge from hospital. People at the rehabilitation unit were encouraged to manage their own medicines following a self-administration assessment.

We found evidence that medicines were not being managed safely at the ground floor rehabilitation unit. One person told us that they were unhappy with their medicines management. The medicines in their blister packs were different from that prescribed at discharge from the hospital and having informed staff, no action had been taken. We found evidence that the person had missed three weeks doses of antidepressants and opioid analgesia since the initial hospital supply ran out and staff told us that the error occurred when a new prescription was obtained from the GP. We saw that a medicine prescribed by the consultant had been out of stock from the pharmacy for five days and evidence was not available to demonstrate that staff had attempted to contact the prescriber for an alternative, despite this being raised by the person. One person who was not able to communicate in English was allowed to manage their own medicines after an assessment was done in English without an interpreter. We saw evidence that this person was unable to manage their medicines safely and was at risk of harm from their medicines.

These medicines concerns were discussed with the registered manager during the inspection visit, who conducted an immediate investigation and implemented, without delay, measures to ensure the safety of the two people. However, the provider had not ensured that people's medicines needs were consistently addressed in a safe way until we identified these issues.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people we spoke with told us they felt safe living at the care home and trusted the staff to protect them from abuse. This view was also expressed by the relatives we met during the inspection.

The provider had systems in place to log safeguarding concerns and record the outcome of the investigations led by the local authority safeguarding team. We discussed each safeguarding allegation with the registered manager and looked at the actions taken by the provider to protect people. Staff told us they had been trained in safeguarding and most were able to competently explain to us about different forms of abuse. Care staff were clear about the provider's safeguarding procedures and said that they would inform their unit leader, the clinical lead nurse or registered manager if they had a concern about abuse or neglect. They were aware of the provider's whistleblowing policy and understood who to contact outside of the

organisation if needed, including the Care Quality Commission. However, some care staff were unclear about the legal protections offered to whistle-blowers. We discussed this finding with the registered manager who showed us documentation to demonstrate that whistleblowing had been discussed at team meetings, and confirmed that the topic would be raised again at individual and group meetings.

Staff wore different uniforms according to their designation (for example, registered nurses, care assistants and domestic staff) so that their occupational role could be identified easily by people using the service and visitors. However, we observed that a few members of staff were not wearing their name badges, which could present difficulties for people and/or relatives who wished to raise a concern about the conduct of one or more employees.

An assessment of risks for each person was included in the electronic system of care records and comprised a number of assessment scores for different aspects of care, including safe moving and positioning, nutrition and hydration, continence, susceptibility to developing pressure ulcers and risk of falls. Each score identified level of risk and all were updated monthly. Where a risk was identified, this was addressed in the relevant care plan with measures to minimise the risk and information about any additional monitoring required. A personal emergency evacuation plan (PEEP) had been developed for each person, which provided guidance for staff if people needed to be evacuated from the premises in the event of an emergency situation.

We saw that all appropriate checks had been regularly undertaken by the maintenance person or by external professional persons, in order to provide people with a safe environment. For example, various fire safety checks were carried out on a daily or weekly basis. Records showed that staff had attended fire safety training and the most recent London Fire and Emergency Planning Authority (LFEPA) fire safety inspection in August 2015 confirmed there were no significant concerns. Other safety tests included the checking of gas detectors, room temperatures, safety of wheelchairs, window restrictors and bedrails, and thermostatic mixing valve temperatures. An external contractor provided monthly pest control checks and there was no recorded pest activity.

Staff told us they received regular updates on infection control. We spoke with two of the domestic staff who showed us the colour coded system for cleaning equipment and explained about their designated duties. Sluice rooms were hygienic, uncluttered and kept locked, as were the cupboards used for storing cleaning equipment and Control of Substances Hazardous to Health (COSHH) materials. All areas of the care home appeared clean and bathrooms had modern fixtures and fittings appropriate for people who used the service. Staff wore protective aprons and gloves when delivering food at meal times and told us that there were satisfactory supplies of the personal protective equipment they needed for providing people with personal care.

Requires Improvement

Is the service effective?

Our findings

We spoke with people and their relatives about whether they thought that staff had the appropriate skills and knowledge to effectively meet their needs. Comments included, "All the carers are nice to me and treat me well", "The rehab is very good, physio very good, the staff are great", "They do look after him/her, they do a good job" and "Generally most of the staff are good, his/her needs are looked after and he/she is pretty much kept clean and tidy." One relative informed us of their concerns about the quality of care and was reluctant for us to discuss their views with the provider, as they were fearful of reprisal. The opinions expressed by people and relatives during the inspection were predominantly positive, although prior to this inspection we had been contacted by people and relatives who told us about significant problems relating to the quality of the service.

Nursing and care staff confirmed they had regular training so that their skills and competencies were kept up to date. All of the staff we spoke with thought that the amount of training was adequate and explained that training took place either in a classroom setting or was delivered via electronic learning modules. Newer care staff told us about recent training, which included health and safety, food hygiene and moving and positioning, as well as a corporate induction and a period of shadowing experienced staff. We noted that some staff had received a limited number of supervisions. However, a sizeable number of staff were recently appointed so their performance was being monitored through probationary period meetings. Supervision records showed that staff were given objectives for improvement following any incidents where their conduct fell short of required professional standards, which were subsequently monitored by the supervisor. The appraisals we looked at showed that staff conducted a self-assessment of their strengths and weaknesses and then discussed their professional priorities for the following year with their line manager, which included training and development needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The Care Quality Commission monitors the operation of Deprivation of Liberty Safeguards (DoLS). These are safeguards put in place to protect people from having their liberty restricted without lawful reason.

Records showed assessments had been conducted where necessary to determine if people had mental capacity to make particular decisions. Staff informed us they had received MCA and DoLS training; however, some staff were not able to explain the principles to us. We did not find evidence of people signing their care plans, or relatives signing the care plans on their behalf if they had been appointed as an attorney for health and welfare. This finding was discussed with the registered manager during the inspection, who showed us several hand – written care plans which contained signatures. We were informed that some hard copy care plan documents had not been uploaded to the electronic care plans we had looked at.

We spoke with people and relatives about the quality of the food, and received some mixed responses. Comments included, "The food is enjoyable, they cook what I actually like and the food is very good. They always give me a cup of tea, they get it right", "Initially I didn't like the food, now I like it. You get a choice of two meals, whichever you want. It comes up really hot" and "The food here is excellent compared with the hospital I was discharged from." One person told us, "The quality of the food varies but the soups are really good" and another person said, "The food is 50/50, some days it's OK. There's no variation on the menu." The relatives of two people were not satisfied with the standard of the food. One relative told us they brought in food for their family member, "because the food here is not suitable, not good quality" and another relative said, "The food is on the cold side by the time he/she gets it. He/she used to get a choice but not now. There are always plenty of drinks available."

Records showed that people's nutritional status was assessed every month and updated on the Malnutrition Universal Screening Tool (MUST). Each person had a care plan which highlighted any issues with eating and drinking such as swallowing difficulties, dietary needs, allergies, cultural preferences and some information on any personal likes and dislikes. People were weighed every month, which was recorded on their electronic care plans and in the paper versions. Daily food intake and fluid charts were maintained in a separate folder for those who were at risk of malnutrition, and these records were up to date. Referrals were made to dietitians, although we found in one care plan that there was insufficient information to demonstrate that the guidance from the dietitian was being followed, as there were no relevant entries in the monthly evaluations recorded by the nursing staff.

We visited the main kitchen which provided food supplied by an external catering organisation. It was clean, well-stocked, and mandatory safety and hygiene records were up to date. We saw the monthly menus with daily meal choices for each day. On the second day of our visit there were two meal options at lunchtime, although no vegetarian choice, and also choices available for the evening meal and the next day breakfast. The head chef said kitchen staff delivered food to each floor using hot trolleys and that people could choose what they wanted to eat at each meal time. They said that ethnic and vegetarian food was available if required, for example Indian and Caribbean food was provided for people who had identified these preferences. Feedback on the food supplied was available informally to catering staff when they assisted staff at mealtimes and at regular resident's meetings, which they attended. The head chef and other staff were fully aware of the dietary requirements of different people living at the service, although we did not find any recorded information to guide them.

People and their relatives told us they generally thought their health care needs were being met in a timely manner, although one person told us they had experienced problems trying to obtain a suitable bed to meet their health care needs. We discussed this with the registered manager and were shown records to demonstrate that actions had been taken in order to support the person and address their concerns. We observed that a person had long finger and toe nails, and was at risk of the toe nails causing broken skin on one of their feet. They person had diabetes, which meant they should have regular foot care monitoring and treatment by a podiatrist; however we did not find evidence of a referral. We discussed this with the registered manager and the clinical lead nurse, who had not been made aware by nursing staff of the need for the person to receive podiatry care without delay. The registered manager told us there was a six week wait for the services of a NHS podiatrist so most people chose to use private services, and stated she would make urgent arrangements for podiatry.

A local GP visited the service three times a week for medical consultations with people, or to conduct general health or medicines reviews. Nursing staff told us that the GP would also make an additional call if a person became acutely unwell. The service was also visited twice a week by a medical consultant for older people, who saw every new person admitted to the rehabilitation unit and also saw people living on the first

and second floors. Health and social care professionals told us that they did not have any concerns regarding the ability of staff to appropriately identify health care concerns and report these concerns to the management team, so that appropriate referrals could be made. We were also told that staff nurse and care assistants followed instructions from external professionals. We noted that although information following visits by heath care professionals, such as tissue viability and palliative care nurses, was comprehensively recorded in a designated 'multi-disciplinary team' folder, it was not always transferred to the relevant section within people's care plans, which could have resulted in people not receiving the care they needed in accordance with the guidance and instructions of external health care professionals.

Requires Improvement

Is the service caring?

Our findings

We spoke with people and their relatives about whether staff were kind and caring. Comments from people included, "The carers here are marvellous to me", "Everyone is very caring, very patient, no complaints" and "Yes, I'm well looked after. I find the staff are very good. They look after me. Very, very good." One person using the service said, "I think the staff are lovely" and another person told us, "I think they really care." One relative told us that staff made sure that their family member was "kept spotlessly clean and the sheets are always clean" which was important for the person's welfare, dignity and self-esteem. Another relative said, "I did not want [my family member] to come here or any care home. The staff told me to come in at any time, as there is nothing to hide. The staff are wonderful people and I am here all the time, they have made me so welcome."

These views were not representative of comments we had received from people and relatives who had contacted the Care Quality Commission to share their views. People who had experienced problems with staffing attitudes ordinarily contacted us after they had completed their rehabilitation programme and returned home, because they did not feel comfortable about raising their concerns while staying at the service. Health and social care professionals reported upon mixed observations about how staff interacted with people. We were told about a caring member of staff who showed considerable compassion and concern for a person whose behaviour challenged the service. However, we also heard that there were staff who could appear curt in the way they spoke with people and relatives.

Staff were generally seen to be focused on physical tasks such as helping people with personal care, transfers and assisting with eating. We noted that some staff referred to people as 'patients'; discussions with staff suggested this was because the ground floor rehabilitation unit was regarded as an acute and short-term care environment. Staff were familiar with people's needs and progress and were able to explain how to support different individuals. We observed that staff were patient and gentle and did not rush people at meal times or when transferring people from one area to another. However there was sometimes little interaction or meaningful engagement between care staff and people. Many people appeared isolated, either remaining in their rooms or in communal areas. We saw limited evidence of staff spending time talking with people in their rooms unless they were performing a practical task. For example, we saw a care assistant sitting in the lounge completing paperwork but there was no interaction with people in the room. However, we also saw another care assistant brushing a person's hair. The person needed reassurance due to their cognitive impairment and was spoken with in a kindly way. The care assistant explained what they were doing and offered to bring a drink. The person became tearful and the care assistant assured them that they were special and valued.

People's preferences were documented to some extent in care plans, including choice of sleeping and waking routines. For example, people were consulted about whether they wished to leave bedroom doors open at night. However it was difficult to tell whether these choices and preferences had been respected as daily records did not contain this level of detail. When asked, care staff had some knowledge of individual preferences. We noted that people were consulted about the gender of staff to assist them with personal care and people were supported to either attend religious services at the home or to maintain links with

representatives of their faith, if they wished to.

We observed that people's privacy and dignity was respected and staff ensured that bedroom and bathroom doors were closed when delivering personal care. Staff we spoke with described the methods they used to ensure that they respected people's privacy and dignity such as offering choice before delivering personal care, explaining what they were doing before helping people and making sure that people were covered as much as possible when receiving assistance with washing and dressing.

People's views and the views of relatives were sought at regular meetings. We looked at the minutes for a meeting that 14 people attended and another meeting attended by 17 people. There were notes to show how the provider had followed up on suggestions from the previous meeting and people were consulted about the quality of the food, a Valentines celebration and an invitation to attend an afternoon tea party at another local service operated by the provider. Useful information was displayed in the premises about advocacy services and community organisations. We were informed that three people had recent contact with either an independent mental capacity advocate or professional advocate at the time of the inspection. Advocates can represent the views and wishes for people who are unable to express their wishes or support people who want to make a complaint.

Requires Improvement

Is the service responsive?

Our findings

We asked people about whether they felt the care and support met their needs. One person told us, "There is nothing but boredom here. Most people spend their time sitting around all day with nothing to do; no entertainment, they just fall asleep" although another person told us they enjoyed the film shows and praised a "superb BBQ with a live band" during the summer.

People's needs had been assessed and individualised care plans were recorded on a central electronic system with a consistent format that was easy to navigate. This system had a comprehensive assessment of each person's risks and needs which took account of their health care and social care needs. There was a delivery plan for each aspect of care with an outline of current needs, expected outcomes and care actions required. There was a monthly evaluation review carried out by nursing staff, which were all up to date at the time of the inspection visit.

Although care plans had been reviewed regularly it was difficult to see any detail of changes to care as the section for monthly evaluations contained no commentary and had just been ticked to indicate that the plan had been reviewed that month. There was no evidence of any overall reviews of care and no electronically recorded evidence of any involvement of people or their relatives in care planning or reviews. We discussed this finding with the registered manager and were shown paper evidence of people's, and their relatives where applicable, involvement in their care planning and reviews.

There was some indication of person centred planning, and some preferences and routines were recorded in the care plans we looked at. For example, we found information about people's preferred time for going to bed and rising, whether to leave on lights and choice of beverages. In some cases this information lacked detail and some people did not have any record of their personal history or background beyond details of family contacts. Staff told us that some people did not wish to disclose information about themselves, particularly if there appeared to have been sad events and various difficulties. However, we noted that other people had regular
visitors who might be in a position to provide additional information about a person's hobbies and interests.

Additional records were maintained in other locations in hard copy files, such as the 'multi disciplinary team' folder, wound care files, food and fluid charts, personal care records and weight records. In some cases this duplicated information in the electronic records but we also found additional information which appeared to be supplementary and gave information about changes which did not appear in the electronic care plans, for example information about the progress achieved with the treatment of pressure ulcers. This meant it was not always easy to track the care and support delivered for each person or clearly identify the most up to date information, particularly as monthly evaluations were not used to summarise monthly progress or changes to care plans.

Daily records of care were maintained electronically by nursing and care staff to document the delivery of care. These were all up to date but tended to focus on physical care and welfare rather than people's emotional wellbeing and engagement with social activities. The monitoring of people's weight, body mass

index and other key measurements were effectively documented in both electronic care plans and in weight books maintained on each unit. There was a separate pressure ulcer care file maintained to record progress and dressing changes. There was good evidence of progress towards healing, including photographs and body maps. However, although hard copy repositioning charts had been established for people at risk of developing pressure ulcers, these had not always been maintained correctly and we found significant gaps in the recording of when people were repositioned. We discussed this finding with the nursing staff and were shown written entries on people's electronic records that reported they were repositioned regularly.

Personal care records were maintained in a separate folder and documented whether people had a wash, shower or bath each day. These records indicated that few people had regular showers or baths. We also noted that the service had received one complaint about a person not being offered a bath or shower. We discussed this finding with the registered manager on the final day of the inspection, who informed us that other records were kept which identified how many people were supported to have a bath or shower. This was a book maintained on each unit that recorded the temperature of each individual bath and shower. This information was sent to us following the inspection visit and indicated that more people received this support, in accordance with their wishes and needs.

We initially looked at End of Life care planning in three care plans. One person who was receiving End of Life care did not have a specific plan in place, there was no relevant medical background in the care plan and visits from palliative care professionals had not been documented in the care plan, although there was information recorded in the 'multi-disciplinary team' folder. All of the Do Not Attempt Resuscitation (DNAR) forms had been authorised and dated by a clinician. However, we noted that there were discrepancies in two of them. One form had been completed in hospital and signed by a hospital clinician. It indicated that the person lacked capacity although this was not documented elsewhere and the care plan stated that the person had discussed DNAR with the GP. Another DNAR, signed and dated by the GP also stated that the person lacked capacity but there was no evidence of this in the care plan as there was no mental capacity assessment and no documentation of a discussion with a family member or advocate. However, the care plan stated the person had discussed DNAR with the GP.

We spoke with the registered manager about the confusing information we discovered. We were shown three other care plans which had appropriately recorded DNAR information. The registered manager told us she planned to ask the GPs to review all of the DNAR forms and has subsequently informed us that this has occurred. The inconsistent information placed people at risk of potentially not receiving care that accurately took into account their health care needs and End of Life wishes.

We found that records did not accurately reflect how the service met people's care and support needs. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with one of the activities co-ordinators, who told us that there were two full-time equivalent activity posts, which were covered by three members of staff. During the inspection we met three sixth form students from a nearby school who regularly volunteered on the unit for people living with dementia. We were informed by the activity co-ordinator that students came every week day for an hour to support activities. They played games such as skittles and basketball, which people appeared to enjoy. They also visited people on the first floor who were bedbound and one student entertained people throughout the service by playing the bassoon.

We were shown some recently purchased new activities such as a bingo machine, magnet darts, musical quizzes, CD's, song books and films. People living with dementia could help themselves to a range of

sensory, occupational and nostalgic items kept in the rummage boxes and we observed the contentment some people derived from choosing favourite items. There was a dedicated activities room next to the main lounge on the second floor unit, which was not particularly inviting.
The activities co-ordinator confirmed that most people preferred to remain within the lounge, hence the provider planned to convert the activities room into a cinema.

We viewed the weekly activities timetable which was designed as a four-week rolling programme. Activities were varied and included armchair exercise, newspaper discussions, baking, flower arranging, pampering, crafts and seated dancing. We observed a baking session. Although only a few people were cognitively able to participate, other people appeared to enjoy watching and tasting the cakes. The activities co-ordinator told us that it was difficult to engage care staff in the activities as they were busy providing people with personal care. Their role also included escorting people to hospital appointments if required, which meant less time to provide activities. The service was due to start weekend shifts for the activity team, which was regarded by activities staff as a positive move to improve the people's social care.

One person told us they had never had cause to make a complaint. They said they never got bored as there was always something to do. A relative of another person said, "I have complained about staff not getting him/her up (from bed). It altered for a while and then returned to the usual." Another relative told us they did not want to make a complaint as they were worried that there would be implications for their family member. Prior to this inspection, we had been contacted by a person using the service and by relatives who expressed concerns about the quality of the care and/or staff attitudes but did not want to make a formal complaint until they or their family members had left the service. People and/or their relatives had subsequently chosen not to raise a complaint, hence the provider was not able to investigate these particular concerns. Where possible with people's permission, we contacted the registered manager and asked them to investigate general concerns so that we protected the anonymity of any people and/or their relatives. The registered manager promptly responded and endeavoured to provide an investigation report.

We saw a copy of the complaints procedure which was outlined in a service user booklet provided for each person living at the service and kept in all of the bedrooms. The procedure was also on display in the reception area and contained clear timelines for responses to complaints. There was information about who to contact within the organisation and externally, such as the local ombudsman. Complainants were advised that they could notify the Care Quality Commission about their experiences of using the service.

We checked the central concerns and complaints file in the office. There were seven separate complaints documented during 2015. Two of these complaints had been promptly investigated and resolved, with clear accompanying records. Otherwise, complaints were not well documented and investigations were sometimes incomplete. It was not always possible to determine the outcome of a complaint or whether it had been resolved, and no analysis of complaints had been done for future learning.
Two of the complainants had to pursue the registered manager and/or provider in order to get responses. We noted that a complaint made in April 2015 had not been resolved at the time of the inspection, although the complainant had contacted the provider on several occasions and received assurances that their concerns were being looked into. Complaints ranged from damage to clothing through to serious concerns about the conduct of a registered nurse.

This was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

We asked people who used the service and their relatives about whether they thought the service was well managed. One person told us they knew who the registered manager was, "They say 'Good Morning' but I have no dealings with them otherwise." Another person and a relative thought they would recommend the service to others and two relatives stated they would not. Other comments from people included, "I think the home is well run but then I don't have nothing to compare it with" and "The manager is very helpful and there are plenty of communications." Relatives told us, "I think it's managed well, they are really nice on the door, this is certainly adequate", "I think this is a good place, he/she is lucky he/she got into this one" and "The head is lovely and brings a great atmosphere and the deputy manager (lead clinical nurse) always personally greets me." The relative of a person with complex needs due to their frailty told us the service was well managed and they were pleased with the care. These mainly positive perspectives were in contrast with information people and relatives shared with us prior to the inspection, in regards to the difficulties they had experienced with the quality of care, staffing attitudes and reported problems not being properly addressed by the management.

Most of the staff we spoke with were positive about the working at the home and felt that the registered manager was very approachable, accessible and supportive. A couple of members of staff were less positive and said that poor staffing levels meant that staff were unable to care effectively for people living at the home and that management were unresponsive to staff concerns. All of the staff we spoke with said they received regular training and supervision sessions at which they could discuss their performance and workload, although the frequency of the supervision varied. However, one member of staff reported that they did not think the management team responded appropriately to being informed that staffing levels were too low. Some said that staff meetings were held on a regular basis while others said that meetings were spasmodic and unhelpful. The minutes of the staff meetings we looked at indicated they were regular and relevant issues were discussed.

We received comments from staff that the turnover was high which was unsettling for people using the service and it had impacted on the staff team's ability to provide consistent care. The staff turnover was discussed with the registered manager and the lead clinical nurse. We were aware that a significant number of people had left within the past 12 months. We were informed that in some cases this was due to standard reasons such as retirement or opportunities for career progression; however, some former staff were described as having been managed out of their positions due to poor performance. The registered manager acknowledged that these changes had temporarily impacted on the smooth running of the service but had also enabled her to recruit new staff that demonstrated the skills, knowledge and commitment to improve the quality of the service.

During the inspection we attended a mid-shift 'communication' session on the ground floor rehabilitation unit. The registered nurse and the two care assistants on duty were present, and were joined by the lead clinical nurse. The purpose of the meeting was for the lead clinical nurse to discuss with staff each person's current situation with particular reference to clinical issues such as repositioning to prevent pressure damage, transport arrangements for discharge, outside appointments, dressings status, discharge

summary, exercise programmes and pharmacy requirements. They demonstrated a thorough knowledge of the current clinical status of the people on the rehab unit. The staff nurse and the care assistants listened to this summation and the information was recorded on a handover sheet. The lead clinical nurse demonstrated an overview of the needs of people on each floor and told us they spent most of their shift working on the different units to support staff, for example they carried out some pressure ulcer dressings to monitor the condition of the skin damage.

We noted that the provider had systems in place to monitor the quality of the service, such as audits and daily 'walkabouts' across the premises by the registered manager. We looked at a report produced by the area manager, which picked up on a few members of staff appearing 'grumpy' and a lack of visible staff on the units. A relative told us there were "a couple of grumpy staff" but did not wish to identify them. The report presented as being open and realistic; however, these visits were every few months and did not appear frequent enough to robustly address shortfalls. The registered manager told us that people and their relatives were sent a satisfaction survey in October 2015 and the results had not been analysed at the time of this inspection. A staff satisfaction survey in 2015 was completed by approximately one third of the staff and did not suggest that staff felt particularly valued by the provider.

Discussions with the registered manager and the lead clinical nurse showed they recognised the problems with the dual use of electronic and hard copy documents, which meant there were too many points of reference to source important information such as the frequency that people were repositioned and whether they were provided with sufficient baths and showers to meet their identified personal care needs and wishes. However, there were other issues that we identified as a concern that had not been picked up by the management team and the provider. For example, one of these concerns was the inadequate staffing levels and the fact that there had been no permanent staff nurse on the rehab unit to fill three 12 hour shifts each week for the past six months. Other concerns included the discrepancies found on two Do Not Attempt Resuscitation forms and the incomplete nature of some complaints from people and/or their relatives. This was in breach of Regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users did not receive safe care and treatment as they were not protected by the proper and safe management of medicines. Regulation 12(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person had not established and was not operating an accessible system for managing complaints. Regulation 16(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured that systems were operated effectively to assess, monitor and improve the quality of the service. Regulation 17(1)(2)(a) The registered person had not maintained an accurate, complete and contemporaneous record in respect of each service user. Regulation 17((1)(2)(c)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Effective recruitment procedures were not established and operated in order to ensure that fit and proper persons were employed. Regulation 19(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of competent staff were not deployed in order to meet people's needs in a timely way. Regulation 18(1)