Acer Healthcare Operations Limited

Appletree Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

This unannounced inspection was carried out on 26 September 2017. Appletree Court Care Home is registered to provide accommodation for up to 77 people who require nursing or personal care and treatment of disease, disorder or injury. There were 61 people living at the service on the day of the inspection. Most of the people who live there are older but the service also supports younger people with disabilities.

This is the first inspection since the service was registered to the new provider in November 2016.

At the time of the inspection there was a manager who had only recently joined the provider and had been working at the service for less than a month. Consequently they had not applied to be a registered manager at the service at the time of the inspection. 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.

Following the inspection the manager left the service and a peripatetic manager took over the day to day management of the service. This person had previous experience working for the provider in a 'troubleshooting' role, and is referred to throughout the report as the peripatetic manager.

People's hydration needs were not always met, as records did not always accurately reflect what people ate and drank. People said they were content with the food provided and we saw people receiving food intravenously safely.

The provider was not always ensuring people were kept safe from harm or abuse as we found instances of people with unexplained bruising. The provider had not investigated the causes in a timely way to ensure people were not at further risk of abuse. People who were able to communicate verbally told us they felt safe living at the service.

There were risk assessments in place for some risks identified but there remained some areas including managing people's behaviours where staff were not always given guidance on how to mitigate risks. We were concerned that people with behaviours that challenged the service were not always receiving appropriate attention as their behaviour charts were not always analysed and the provider had not always sought the advice or intervention of mental health professionals.

We found there were insufficient staff to meet people's needs and this impacted on the quality of care provided to people.

The provider undertook quality audits but did not always follow through in a timely way on actions identified. This meant people were left at risk of receiving poor care.

The majority of people were positive about the staff. Whilst we found the majority of care staff did support people's dignity and respect, we saw one person left in an undignified state for a period which was of concern.

People received health care for physical health issues and we saw where people had pressure areas remedial action was taken to improve this, with appropriate health support requested by the service.

There was an activities co-ordinator working at the service who arranged some activities but as the service was split over three floors this meant there were limited activities taking place. There was a well maintained garden at the service which people enjoyed sitting in.

Medicines including controlled drugs were stored and administered safely. The service was clean throughout.

Staff were safely recruited so were considered safe to work with vulnerable people.

The service was working with the local authority to ensure all the necessary documentation was in place where people's liberty was being restricted.

We found the provider was in breach of six fundamental standards. These related to the safe care and treatment of people using the service, safeguarding people from abuse and staffing. The provider was also in breach of standards relating to meeting people's nutritional and hydration needs, dignity and respect and the governance of the service.

We have made recommendations in relation to Do Not Attempt Cardiopulmonary Resuscitation documentation and staff supervision.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We took enforcement action against the provider by serving three enforcement warning notices.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risk assessments were not always in place to provide guidance to staff on all risks identified.

There were insufficient staff to meet people's needs.

Medicines were safely managed. Recruitment of staff was safe.

Is the service effective?

Requires Improvement

The service was not always effective. The provider did not have evidence that people had access to sufficient fluids to maintain their good health and wellbeing.

Supervision had started to take place in recent months.

People received support to access health care services to meet their physical needs. We were concerned people did not always have the support of mental health professionals as required.

At the time of the inspection DoLS applications were in place for the majority of people who needed them and the provider was liaising with the local authority to ensure any outstanding applications were identified.

Is the service caring?

Requires Improvement

The service was not always caring. We witnessed care that was not always conducive to dignity and respect.

People living at the service told us the staff were kind.

Relatives acknowledged staff were caring within the constraints of staffing levels.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not always person centred and the quality of care plans varied across the service.

There were some activities at the service but these were limited

as the activities co-ordinator worked across three floors.

There was a complaints process in place and a log of complaints was kept, although the provider did not always show us complaints were dealt with within stipulated timescales.

Is the service well-led?

Inadequate

The service was not well led. Although the provider carried out quality assurance audits, remedial action was not taken in a timely way to improve the quality of the care.

For a period of six months no staff meetings had taken place and minimal supervision had occurred. This meant staff did not always receive formal guidance on a regular basis.

The provider did not ensure there was management oversight of safeguarding concerns.

Appletree Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 26 September 2017 and was unannounced. The inspection was carried out by three inspectors, a nurse specialist advisor and one 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 the inspection we looked at information CQC held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We also spoke with external stakeholder organisations who gave their feedback about the service.

On the day of the inspection we spoke with 11 people using the service and ten relatives. We also spoke with the manager, the deputy manager and the Quality Assurance Manager. We spoke with four care staff and one nurse and walked around the premises including viewing people's bedrooms.

We looked at 11 people's care records and four staff records. We viewed policies and procedures, training and supervision information, and accidents, incidents and safeguarding records. We checked medicines administration records for six people. We also checked medicines stocks against records and checked records relating to the premises safety.

Following the inspection we spoke with the Regional Director, the peripatetic manager and the Quality Assurance Manager. We obtained feedback from three health and social care professionals who had knowledge of the service, and spoke with three additional relatives and an advocate of a person living at the service.

Inadequate

Is the service safe?

Our findings

We asked people who could communicate verbally if they felt safe at the service. People said, "I feel safe", "Staff look after me well. No complaints" "Staff very good, very nice." And "I feel safe. Things happen in an ordered way, no sudden surprises."

People were not always safeguarded from abuse and neglect. The provider was not following their own safeguarding procedures to take any actions necessary to keep the adult at risk safe. We saw that there were six unexplained injuries sustained by people at the service across a three month period from July to September, two of these were pointed out to the provider by external professionals visiting the service. There were also three injuries sustained by people from other residents with behaviours that can challenge over the same three month period.

The provider could not evidence they had taken an overview of the increase in number and extent of unexplained bruises in the period July to September 2017 to determine if there was a pattern to these occurring. This meant people remained at risk of further abuse.

The relatives' meeting minutes of 5 September 2017 noted a number of relatives were concerned about the behaviours of some people against others; and the manager and provider's Regional Director acknowledged some people may have been placed wrongly at the service and that the provider planned to re-assess people's needs to ensure they were able to meet them at Appletree Court Care Home.

Without prejudging the outcome of these safeguarding investigations, these injuries were of concern as the provider did not show us there was management oversight into the causes and so people were not always protected from abuse or improper treatment.

These were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of writing this report there remained safeguarding concerns which were being investigated by external organisations.

On the day of the inspection there were insufficient staff to meet people's needs and keep them safe. For example, on the first floor one person required intensive supervision as there had been previous incidences of this person assaulting other people living at the service and this person had not been assigned additional staff to supervise them. We witnessed two people walking up and down the corridor who then went into other people's rooms and were verbally rude to them as staff were not supervising them closely enough to prevent this.

The quality of care was compromised by a shortage of staff. We saw one person waited for over an hour to be supported to get up. There was a strong smell of faeces in this person's room. One member of staff commented, "I need to wash [person's name], but there is something I need to do first." Another member of

staff went in and said, "We are going for a shower," but then left the room.

By lunch time at 13:00 eleven people were up on one floor. It was not clear whether the remaining twelve people were in bed through choice or because there were not enough staff to get them up in time for lunch. When we asked a staff member they were unable to clarify this or confirm who was bed bound.

We asked a staff member on one floor if they thought there were enough hoists. They told us, "I think there are two hoists. I think it's enough." However, another staff member told us, "There are not enough hoists. We can't get [person] up because we are waiting for a hoist." One relative told us, "Five weeks ago I found mum in bed at lunch time so she was 17½ hours in bed for someone with history of pressure sores." This had been logged as a formal complaint by the service. We were made aware by the local authority investigating this incident that it was not possible to substantiate as care records did not record when a person went to bed or got up.

We also witnessed a call bell ringing for 12 minutes unanswered. Realising a member of staff had not responded, a member of the inspection team went to the room and asked if they could help the person. The person told them they had now forgotten what they wanted.

We asked people if they thought there were enough staff to meet their needs. They told us, "Not enough carers. They have to help out on other floors." Another person said, "Not enough both day and night." A third person said, "I don't talk much as they are too busy to talk to you properly. They came to change my pad at 05:00 this morning. I did not call them."

Nine out of thirteen relatives told us they were concerned at the level of staffing. One family member said, "Staff do a tremendous job under difficult circumstances. Staff intentions good but under ridiculous pressure." Another relative told us, "They are short of staff. " Another said, "Not enough staff on this floor. Especially at night" And another said, "They are trying. Appalling staff levels."

A staff member told us, "there is absolutely no time left for the nice bits like sitting chatting to residents." Another told us, "There are many times when we do not have the full complement of staff on shift; weekends are the worst." And, "Even though we are not full on this floor, management is telling us we are overstaffed just because we are not full." We were also told "to be honest, we don't have enough nurses and we struggle in the morning because there is so much to do in a short space of time by so few staff. It is too much for one nurse."

We were concerned at the staffing levels at night, particularly given the requirement to closely supervise at least two individuals due to concerns regarding their behaviour for themselves or to others. Relatives told us they were most concerned that there were insufficient staffing levels at night to ensure people were safe. A staff member told us, "cover at night is very tight. If the one nurse who is on night duty on that floor is doing medication, then that leaves just one carer on that floor who frequently needs assistance."

Due to inadequate staffing levels, we found that people did not have showers as regularly as their care plans stated they would like them.

The above concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following this inspection the service increased staffing levels at night by one carer across the service.

We saw there were some risk assessments in place. These included assessments for bed rails, diabetes and moving and handling. People with the risk of choking had care plans in order to mitigate the risks. There was also information and posters to support staff in preventing choking and dealing with it should it occur.

However, we noted one person's moving and handling risk assessment and manual handling support plan did not clearly set out how to evaluate how to support this person given they had a fluctuating health condition which required significantly different levels of moving and handling support. This lack of clarity could place this person at risk of falls and unsafe care by staff.

We also found there were not risk assessments in place for all the people who had behaviours that challenge. For example, we found one person repeatedly used their call bell which meant staff were constantly interrupted. We also noted there were 16 instances of behaviours that challenge noted on a behaviour chart for one person, the majority of which had occurred when staff were assisting with personal care. However, there was no guidance for staff in how best to support this person to reduce the behaviour which then placed people at risk of unsafe care.

There were risk assessments in place to protect people from falling out of bed. However, we noted one room with bed rails in use without bumpers. There was no risk assessment to explain why no bumper was in place. The staff confirmed that bumpers were not fitted to this bed and the bed rail had been in use. This could expose the person to the risk of entrapment.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of developing pressure ulcers. People's records specified they should be supported to turn over in bed to relieve pressure on their skins. People were nursed on pressure mattresses to protect them from developing pressure ulcers and also to help blood circulation. Records showed that pressure mattresses were checked at least daily. One record showed that staff had supported a person to change positioned every two hours as indicated in the care plan. Photographs taken on a monthly basis showed a person's pressure ulcer had improved and was healing. Staff knew how and when to refer people to the local NHS tissue viability nurse (TVN) in order to get advice about the prevention and management of pressure ulcers. Care plans showed evidence of the involvement of TVN. The wound plans showed how guidance and recommendations by TVN have been incorporated into care plans. Waterlow assessment tool was used to assess people with the risk of pressure ulcers. They were reviewed monthly.

Records showed that pre-employment checks were carried out before staff started work. These included two written references, proof of identity as well as their employment history and a criminal records check. This showed that there was a system in place to ensure staff were suitable to work with people at the service.

Medicines were supplied in blister packs for individual people in a four week cycle. Medicines were stored safely in a locked cupboard in a clinical room. Medicines to be given as and when required, such as paracetamol, was ordered in boxes to avoid wastage. A balance of the medicine was recorded every time medicine was dispensed. This was brought forward each month. There was no over stocking of medicines. Unused medicines in the blister packs were collected by a licensed drug disposal company every month. However, we informed the manager that labels should be removed and disposed to protect the confidentiality of the person.

There was a controlled drugs register for the recording, receipt and administration of controlled drugs.

Controlled drugs were recorded in the register on arrival by two qualified staff after being checked and signed with a running total. Controlled drugs were checked by a second staff prior to administration. Records showed that the register was signed each time to confirm that the drug was checked and administered. There were no gaps.

Medicines requiring cool storage were stored safely and temperature was recorded and maintained at a safe level. There were no gaps in recording.

We observed a nurse dispensing medicines wearing a 'do not disturb tabard' to avoid being distracted from the task. The nurse observed the six principles when dispensing medicines, to ensure that he gave the right medicine, in the right dose, right strength, at the right time to the right person and respect their right to refuse.

Where it was considered that a person lacked capacity to understand the consequences of their refusal, administering medicines covertly was used as a contingency measure in the best interestf the person. Records showed involvement of a pharmacist, GP and relatives. There was a care plan in place and this had the agreement of the pharmacist and doctor and also the method of administration. This was reviewed monthly.

We checked the service and found the kitchen was clean as were bathrooms, bedrooms and the communal areas. Food was stored safely and temperature checks were kept of fridge and freezer temperatures. The service had been given the highest rating for food hygiene in January 2017 by the Food Standards Agency.

We saw staff using gloves and aprons the majority of the time. However we discussed some concerns in relation to infection control with the manager and Quality Assurance Manager as we witnessed staff walk along the corridors carrying soiled materials without gloves on, on three occasions. We also observed on occasion a staff member leaving the trolley with soiled incontinence pads in the corridor after they had changed a person. This contributed to malodour in the corridor. Best practice would be to take clinical waste bagged to the sluice room and dispose of immediately.

Records showed that routine health and safety checks took place such as checks on window restrictors, electrical beds and call bells. The dates on the hoists showed that they had been checked and serviced within the due date.

Requires Improvement

Is the service effective?

Our findings

The provider did not evidence people received effective support to drink enough to stay hydrated. We had concerns regarding two people's fluid charts. For one person we noted that over the period 15-25 September 2017 their fluid intake had varied daily from 80ml to 1340ml. On six days the intake recorded was less than 800ml. There was contradictory information recorded on daily notes on two occasions, for example, stating this person ate and drank well despite low fluid intake. On nine other days there was no recording in daily notes of the amount taken. There was a consistent failure to identify the target amount over 24 hours. We also found for this person there was no care plan about fluid intake and no guidance to staff about how to encourage fluid and what amount.

We had similar concerns regarding a second person's fluid chart. Over a six day period we found four days in which intake was less than 1000ml, one day there were no records available and another day intake was 1000ml.There was no target amount identified for this person.

These concerns placed people at risk of dehydration, and the provider was not able to show us people had had enough fluids to maintain good health and wellbeing.

We raised these concerns with the manager and Quality Assurance Manager on the day of the inspection and that evening the manager, deputy and Quality Assurance Manager checked fluid charts for all residents across the service and found concerns with an additional four people's fluid charts. The provider raised safeguarding alerts for all six people.

These concerns were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The day after the inspection the provider told us they had referred people with low fluid intake charts to the GP for review. They had also met with staff to ensure they were clear about actions to take if fluid targets were not reached.

Following the inspection the provider sent us evidence they are checking fluid charts daily and they told us any concerns would be passed on from one shift to the next, and any gaps or anomalies would be explored with staff. They were also reviewing the number of people whose fluid was being monitored to ensure there was a clinical need for collecting this information.

We witnessed a nurse feeding a person using a device directly into their stomach. This is known as percutaneous endoscopic gastrostomy or PEG feeding a person. They demonstrated good skills and knowledge of the procedure and person. We saw there was the involvement of a doctor, pharmacist, specialist PEG support nurse and dietician incorporated in the care plan. Regular reviews had been carried out by the specialist PEG support nurse. The nurse displayed good hygiene in relation to this procedure and equipment and positioned the person at the appropriate angle to receive the feed.

The meal we saw looked hot and appetising and people enjoyed it. People told us they were asked the previous day what they wanted to eat. People told us, "Food enough for me, not a good eater. Sometimes I like it and sometimes I don't. If I don't like I leave it and they just come and take it away." Another person said, "Food very good. Usually eat what they put up. Usually get a choice." And "Food is nice. I don't complain. I just sit down and enjoy it." One relative told us, "My wife has denture problems and they cut up her food into small pieces and help her if necessary, diet is adequate for her needs." Only one person we spoke with was very unhappy with the food and told us, "It is very bad. They ask what you want for the following day. You never get it."

On the first floor we noted lunch was eaten at different times to enable people to be supported by staff. However, one person in the lounge became very agitated while waiting for their lunch. The staff member who plated up the food did not have a list of people to include those in their rooms, and although staff told us people had been given a meal, lunch organisation lacked structure.

One person in their room ate very little. Their food chart completed at 13:35 hours stated the person had eaten a quarter of the main meal, a quarter of desert; and drunk 50 ml of juice. However, the tray of cold food was in the person's room at 14:15 only two spoonfuls of the main meal appeared to have been eaten; pudding was untouched and so was the glass of juice. This meant that records did not accurately reflect what the person ate and drank which was of concern.

This concern and the lack of accurate recording in daily notes referred to above in relation to fluid charts were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could see from records that people had access to primary and secondary health care, including GPs, dentists and opticians to cater for their physical health.

Whilst we saw some evidence of input from psychiatric services, some people's mental health was not being well managed. For example, one person on the first floor had 16 instances of behaviours that challenge during September 2017 related to screaming and pinching staff during personal care. However, there was no support plan for behaviour nor for communication on their care records. We heard this person call out from their room and also while sitting in the lounge. Although ABC behaviour charts were being kept for this person there was no analysis of the behaviour or evidence of seeking advice in understanding the reason for the behaviour and meeting the person's needs from other health professionals.

We found a similar issue of concern for one person on the first floor. We found ABC charts completed for a person, the majority of which were completed by one member of staff as out of 24 entries they had completed 22. Although the staff member told us the behaviours were continuous over a period from March to August 2017, the charts had been completed from 15 March 2017 to 16 April 2017 and then started again from the 23 August 2017. There was no evidence that the data from the ABC charts had been analysed. There was no evidence of the involvement of either the community mental health team or the psychologist. Their involvement would be key in identifying reasons for the behaviour and putting a plan in place to effectively support the person and reduce the behaviour.

The provider has acknowledged that whilst there was a policy in place regarding behaviours that challenge it did not provide sufficient guidance for staff and was in the process of being reviewed at the time of writing this report. This failure to obtain support from healthcare professionals for people left them and others at risk of unsafe care.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The peripatetic manager told us that following the inspection a training course was set up for staff at the end of October 2017 to support them with the completion of behaviour management recording and management.

The majority of training was done as e-learning and the company expected all staff to complete the training. Completion rates for mandatory training was 95% for safeguarding vulnerable adults; 89% for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS); 89% for Dementia; 98% in fire awareness; 91% for manual handling; 94% for First Aid; 89% for health and safety. We noted that where training was classroom based, compliance rates were much lower. For example, practical fire training was 38% and manual handling training was 49%. This meant that the majority of staff completed online training but less staff attended practical training. There was a planned practical training course scheduled for the day of the inspection, but the manager told us this would be rescheduled for another day.

Staff said they had training appropriate to their roles and gave examples. One member of staff told us they would prefer more practical and face to face training in preference to the on-line mandatory training. We saw staff hoist a person safely. They sought consent and talked the person through the process. The person appeared to be calm and comfortable.

Although most staff had been trained, not all the staff we spoke with demonstrated a good understanding of DoLS and MCA and what this meant for their role.

Staff had not received regular supervision since February 2017. Thirteen out of fourteen supervision records checked showed that supervision last took place in either January or February 2017. Four supervisions had been undertaken during August 2017. The supervision policy stated staff should receive four supervisions a year. Staff told us they felt supported by senior staff and that team working was strong.

We recommend that supervision is prioritised and the provider takes action to ensure that staff understand training undertaken.

People were generally positive about staff but there was often an acknowledgement that they were under pressure and as a result task focused. One person said "Excellent. Not enough, day and night. They work hard." A relative told us, "I am very satisfied with the nurses. Very helpful." Another said, "99% are genuine carers doing badly paid job well." A number of relatives' views were influenced by their perception of there being insufficient staff on duty. For example, one relative said "They do their best. I did complain today as she smelt so I told the carer." Another said, "Mum needs moving back when [she] slips down the chair. Yesterday she had slipped down when I came, had to find carers to lift her."

Staff told us that for people with complex mobility needs they used a full body sling with full body hoist. Each person had been measured for their individual sling. These were washed regularly. A staff member told us "We always have two trained people when we use the hoist. We never use the hoist on our own. When we have agency staff we get somebody who has been trained. The permanent staff always take the lead when using the hoist." We saw people being transferred safely using hoists on the day of the inspection. We were made aware of a complaint related to one staff member using a hoist on one occasion. The provider had addressed this with the staff member, and reported it was to avoid a person falling. As the person no longer lived at the service this had not been dealt with under safeguarding procedures as would normally be the case.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We could see from records that at the time of the inspection there were DoLs applications for some people and the manager was liaising with the local authority regarding those who required a DoLS applications, and those awaiting an assessment.

The service is provided in a building on three floors. Each floor is accessible by a lift, so it is suitable for people with mobility needs.

Requires Improvement

Is the service caring?

Our findings

Staff were task orientated and because they were busy did not always recognise when people needed support. For example, staff walked past a person in their room who was lying on a mattress that had been stripped and the person had no clothes on their lower half. The person stayed in this state until staff supported them to get up half an hour later. This was not conducive to providing dignity and respect to a person.

We noted that one person had a total of eight showers between 1 July and 25 August 2017 instead of three per week as stated on her care plan, another service user had six showers for the same period instead of three times per week as stated in her care plan.

These concerns were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked a staff member about the regularity of people's showers. They said that where a person required two carers to support them it was difficult at times to give people regular showers due to other work commitments. One person told us in relation to having a shower "You can do it yourself or ask them to help you. The lady in dark blue is very good."

There were ways in which we saw staff treat people with dignity and respect. We saw people drawing the curtain around a person before providing care. The person's body was covered with the exception of the area required to PEG feed the person and staff could tell us how they ensured people were provided with dignity and respect.

People living at the service who were able to communicate verbally were positive about staff. One person told us, "Very kind. They help you if you're not feeling well." Another person told us "It's quite nice here." Another said, "Staff don't boss us about. I feel very comfortable." Another said, "Very nice here. Got everything you want."

One relative told us "They do their best." Another said "Staff intentions good but under ridiculous pressure. Difficult to do this with compassion and dignity." A third said, "Staff take a lot of stick but are understanding and patient."

A family member told us their relative was supported with their cultural and spiritual needs. "She is Jewish but not bothered about Kosher food. She eats good. The Christian Minister who visits talks to her." One person told us "The priest is absolutely lovely. He comes to see me. He gives us communion."

Care records were not routinely signed by people living at the service nor was there other evidence that care plans had been discussed with people and that they agreed with the care plan. We also saw that there were some 'Do not attempt resuscitation' DNACPR forms completed but it was not always clear that people had been involved in this process of decision making or if not, why not. The service was in the process of

upgrading to an electronic care system. The peripatetic manager told us the new system would capture people's views and those of their relatives.

We recommend the provider reviews all DNACPR forms to ensure people have either been involved in the decision making process or the reason for this not happening is recorded.

People's room were personalised with their own effects. There was a garden for use by the people living at the service. There were raised beds with flowers and plants which meant people in wheelchairs could help with gardening. The garden was well maintained. The service had won second prize for their garden and floral display in a competition run by the provider nationally. There was an area in the garden that had been set aside as a 'beach area' with sand and a mural, but the provider told us this was due to renovated to become a covered area for people who smoked. The living room opened onto the garden which meant fresh air was able to move freely around the room which was positive for people using the room.

Requires Improvement

Is the service responsive?

Our findings

Care records were in different formats and the provider explained that an electronic system was being implemented. This meant that some care records had more information on them than others. There were support plans in place for a range of areas including moving and handling, personal care, nutrition and skin care.

We found little information that was personal to people or that described their preferred routines. One example of this was care plans did not reflect people's preferences for times to get up and go to bed. This meant that care records were not person centred.

Although the Quality Assurance Manager told us there was a key worker system in place at the service it was not clear what exactly this meant for their role. They also acknowledged that people were not meeting regularly with their keyworker to review their care or discuss how they would like it to be provided. For example, one person told us "It is very difficult to get a newspaper. I urgently need stamps but do not know who to ask." Whereas another person told us they knew how to order a newspaper.

There was no individual activity programme based on the person's hobbies and preferences in the care records. There was an activities co-ordinator at the service and we were made aware that there were some activities taking place at the service. There was a weekly programme displayed on the notice boards. These included ball games, chair exercises and arts and crafts. There were musical performers on occasion at the service and the co-ordinator took small groups of people out to lunch for special occasions. The co-ordinator told us they supported people to go into the garden and they spent time with individuals who were bed-bound. A Breakfast Club was run on the first floor. The activities co-ordinator also drew together a monthly newsletter for people and their relatives to keep them up to date with news and activities at the service.

However, the service was spread across three floors and this meant that by having one person for activities, these were limited. There was very little stimulation for people across the three floors of the service. As staff were busy with tasks, they did not always have time to speak with people as they went about their daily routines.
We saw the activities co-ordinator engage people in chair exercises during the afternoon on the first floor. However, much of the activity co-ordinator's time was taken up with supporting care staff to manage people's needs.

We saw some people talking amongst themselves and there was a friendly atmosphere. There were mixed views about the activities from people and their relatives. One person told us, "Can't say a lot. Just finished knitting a belt. I read a newspaper and books. Don't know if activities are organised. Occasionally a visitor comes in doing something but not getting us to do anything." Another person told us, "I do bingo. Went out yesterday for a meal. Out in a minibus. Not really any entertainment."

Other comments included, "Very nice here. Got everything you want." And, "I sit in the lounge and watch TV.

When weather is nice I sit in the garden. I read magazines. They bring in newspapers. I can order but I don't. They have exercises and I join in if I can. There is enough to do. I have made friends here."

Relatives told us, "She enjoys singing and a young lady does a few things including lunches out and they went to a carvery last week and Brighton the week before." But another relative told us, "Lack of activity and stimulation comes up at every residents meeting. You come in and all are just staring at each other." We saw the minutes of the relatives meeting in September 2017 and the issue of activities was raised with some relatives noting people were not happy with the level of activities.

The provider told us they were starting a review of activities provided at the service with the aim to establish a robust, yet flexible programme, based on people's individual wishes and abilities. The provider anticipated that they would have any changes in place ready for the start of 2018. But in the meantime they would endeavour to ensure that everyone had access to activities in the home.

The service had a policy on how to manage complaints. Their policy was to respond to complaints within 28 days. Records showed that complaints were logged by the organisation. We found not all complaints had been dealt with in a timely way in the period between the registered manager leaving and the arrival of the peripatetic manager. Some of these delays related to complaints also being the subject of safeguarding investigations which were being investigated by the local authority. The peripatetic manager was dealing with outstanding complaints at the time of writing this report.

Relatives meetings had taken place in September and October 2017. We saw a range of issues raised by relatives ranging from staffing levels, to managing behaviours of people whose behaviour challenged the service. The meetings were used by the management of the service to update relatives on current issues. We discussed with the peripatetic manager the range of issues of concern raised at these meetings were broader than the range of complaints logged by the service. Their view was that unless people raised issues as a complaint the information obtained and raised at the meetings was generic information of use for service improvement but not a complaint.

We asked people if they knew how to make a complaint. People told us "If I had a complaint I would go to the deputy manager. I have made many complaints. I have complained about night staff." Another person said they if they had a complaint; "I would go to the manageress. She is a new lady and she's been in."

Inadequate

Is the service well-led?

Our findings

The provider carried out some audits in the service. We saw that medicines audits took place on a monthly basis.

We looked at the provider quality assurance reports over a period from May to September 2017. We found that whilst the range of areas audited was comprehensive and an action plan was developed, it was not always apparent that remedial actions identified were implemented in a timely way. For example, the Quality Assurance Manager noted in May 2017 that there were three people who had fluid charts with people not reaching target fluid amounts, and fluids were not always being recorded. One of the actions noted was "Where targets are not reached or care not given as required, appropriate actions should be taken (as discussed)." The target date for completing this work was 1 July 2017. Subsequent provider reports in June and July noted the action was not completed and timescale extended to 1 August 2017 and then 1 September 2017 There was no reason given for the first extension to 1 August 2017. The July provider report stated the second extension to 1 September 2017 was to give time implement a trial scheme for those at risk of low fluid intake, but this was not in place at the time of the inspection.

We found two fluid charts of concern due to low fluid intake and lack of recording. Following the inspection the provider found more fluid charts with similar issues. The provider then notified CQC and the local authority of these concerns under the safeguarding procedures. This was a delay in the provider identifying then acting on a risk to people's health.

We saw the June 2017 provider quality assurance report noted "There does not appear to be a clear rationale for residents staying in bed or being supported to get up. I asked the Deputy Manager to speak to staff about this, and ensure reasoning for this is sound and is addressed in care plans." Target date for achieving this was noted as 21 July 2017. The July 2017 report noted the timescale for this target date had been changed to 1 September 2017 and remained so during the August provider quality assurance report. The September provider quality assurance report noted the target date had changed to 1 October 2017.

This was evidence of inadequate action being taken in response to identifying risks to people's safety and their wellbeing.

During the inspection, we found over half the people on the first floor were still in bed at lunchtime. Staff were unable to tell us if people were in bed through choice, were bedbound or because they had not had the opportunity to get people up.

Subsequent to the inspection, we were given information by the provider that showed that there was a rationale for only two people to routinely spend 16 hours in bed on the first floor. The provider had put a document in place which identified who chooses or needs to remain in bed and who else should be offered the chance to get up out of bed. It is important for people to maintain maximum mobility in line with their ability to maintain maximum health. Reduced mobility also makes people at risk of developing pressure areas.

These concerns illustrated that the quality assurance process identified quality issues of concern however the provider did not monitor and improve the quality and safety of the services or mitigate the risks to people to ensure their good health, safety and welfare.

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had taken over the service in November 2016 and in the last 12 months there had been three managers. We saw that there were no records of staff meetings from January 2017 until 28 July 2017. During this period there was also minimal staff supervision taking place. This meant there were few opportunities for staff to collectively or individually feed back on a formal basis, their experience of working at the service. We could see staff meetings took place in July, August and early September 2017 but not prior to this in 2017. Staff told us they felt supported by senior care staff and that team working was strong at the service.

We asked people and their visitors their view of the service. There were mixed views. One person told us the home "It's run smoothly. It's extraordinarily peaceful." A relative told us, "[X] has been in four different care homes and this one makes you feel welcome. You see staff giving residents a cuddle even if ten minutes ago they were obnoxious. I know the manager. I would recommend this Home to other people."

However, relatives also noted the change in provider and of the management of the service. One relative told us "It was a big upheaval when the manager left, it distressed me." Another told us, "I am going to take wife home. Management incompetent. Atmosphere changed when the new company bought it." A third relative said "It appears to be well run but difficult to say as we have seen but not met the new manager."

Since the inspection there has been another change in management of the home and a peripatetic manager was overseeing the day to day management of the service at the time of writing this report. They planned to remain at the service until a permanent manager was recruited and inducted into the post. The peripatetic manager's role in the organisation was to 'troubleshoot' and help to raise standards in services where there were concerns.

The peripatetic manager told us they were meeting regularly with staff to offer them practical support. They were reviewing people's care and care records regularly. For example, they were reviewing who needed food and fluid charts at the service and why people had been identified as needing them. The peripatetic manager had also identified some staff would benefit from leadership training to improve their skills in the management of staff working for them on a shift. In this way the peripatetic manager planned to assist staff in prioritising their work and support them with skills to manage shifts effectively. The peripatetic manager acknowledged the negative impact of having several managers at the service within a short period of time and told us they were keen to empower staff and help them regain their confidence in their own ability.

The peripatetic manager told us that the provider was due to implement a new electronic care system which would streamline the care recording process. The provider was offering support with the implementation and the new system would be phased in one floor at a time to ensure the change did not adversely affect care. Whilst the implementation of a new system was in itself an additional task to achieve, the peripatetic manager thought it would resolve a number of issues. These included streamlining the care recording process so there were no longer different formats of care plans; it also provided staff with a chance to review people's care needs and ensure their care records reflected these accurately.

The local authority quality improvement team had been supporting the provider following the inspection. For example, the peripatetic manager told us they were running a training course for staff in behaviour

management in November 2017 and were visiting the service regularly to monitor care. The service was also accessing additional skills and training from the provider to support them to improve the care at the service. This included training workbooks for staff regarding hydration, and a 'Dementia Bus'. This was an experiential course to assist staff in understanding the day to day experience of people with dementia.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure people were treated with dignity and respect including failing to maintain privacy for one person. Regulation 10 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always assessed the risks to service users' health and safety or put in place plans to mitigate risks. Regulation 12(1)(2)(a)(b) The provider did not ensure that timely care planning involving other professionals took place to ensure the health, safety and welfare of service users. Regulation 12(1)(2)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not always ensure that service users were protected from abuse and improper treatment due to a failure to prevent and to investigate in a timely way allegations or evidence of such abuse. Regulation 13(1)(2)(3)

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider could not always evidence the nutritional and hydration needs of service users were met. Regulation 14(1)

The enforcement action we took:

Issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure monitoring procedures effectively assessed, monitored and mitigated risks to service users' health, safety and welfare. The provider did not evaluate and improve their practice in respect of the processing of information gained from their own quality assurance processes. The provider did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided. Regulation 17(1)(2)(a)(b)(c)

The enforcement action we took:

Issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the requirements of the service users living at the service. Regulation 18(1)

The enforcement action we took:

Issued a Warning Notice