Parkfields Nursing Home Limited

Parkfields Nursing Home

Inspection report

556 - 558 Wolverhampton Road East
Parkfields
Wolverhampton
West Midlands
WV4 6AA
Tel: 01902 621721
Website: No website.

Date of inspection visit: 18, 19 November 2015 and 12 January 2016
Date of publication: 29/04/2016

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**

Overall summary

The inspection took place on 18, 19 November 2015 and 12 January 2016. The inspection was unannounced.

Our previous inspection of the service on 16 and 18 June 2015 identified three breaches of legal requirements. This was because people's medicines were not managed safely, people's consent to care was not always sought and effective systems were not in place to ensure people were protected from unsafe care and treatment. The provider wrote to us after this inspection to say how they were going to meet legal requirements in relation to the breaches. This inspection was undertaken to see if the provider had made improvement to meet the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We found the provider had met the regulations with respect of medicines and consent although there was still some scope for improvement in respect of how people's medicines were managed. The provider had not completed all the actions needed in

Summary of findings

respect of management of the service and remained in breach of this regulation. We also found a further breach of regulation with regard to the safe care and treatment of people who used the service.

The overall rating for this service is 'Inadequate' and the service remains 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 improvements are made within this timeframe, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This service will continue to be kept under review.

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.

Parkfields Nursing Home provides care and treatment for up to 49 older people that may have a physical disability. The home provides nursing care, which means qualified nursing staff are always available. There were 29 people living at the service when we commenced this inspection.

The service did not have a registered manager at the time of our inspection but the manager has since registered with CQC. 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. An application for the manager to register has now been received.

People told us that they felt safe; however we found moving and handling practices the service used were not always appropriate for people's individual needs and may have put them at risk. Improvement had not been made to this, despite the provider being made aware that a significant injury a person sustained was very possibly, although not conclusively, due to the use of an inappropriate lifting sling.

People told us they were happy with their care but there were occasions where staff did not show them respect or promote their privacy and dignity. The manager and staff had a good understanding of how they should keep people safe but concerns about people's welfare were not always escalated appropriately and so appropriate action had not always been taken. People said they sometimes had to wait for assistance although this had not led to people feeling unsafe. People told us they were given their medicines when needed.

People told us, and we saw care and support was not consistently provided in a way that showed staff were kind and considerate. Staff told us they were aware of people's care and support needs, and the provider was progressing training for staff to develop their skills and knowledge. People were supported to make their own decisions and choices in accordance with their best interests. People's healthcare needs were promoted through contact with appropriate healthcare professionals.

People told us they were satisfied with the food and drink they had and this was provided for most people when requested and in sufficient quantities. Records showed some people did not have as much to drink as they were assessed as needing and these concerns were not recognised in November 2015. Systems to identify when people did not have enough to drink had improved in January 2016. We saw staff provided appropriate assistance to people that needed help to eat and drink although the timeliness of this support was not always consistent. We found systems were in place to ensure people at risk of weight loss were monitored.

People told us staff were kind to them, but we saw some staff did not support people in a way that was caring. We did see some people had good relationships with the staff who supported them. Some staff demonstrated a good knowledge of what was important for people and what was recorded in their care records; although there were occasions when staff did not know what was important for people or communicate effectively with them.

Summary of findings

People's needs were assessed and their support plans provided staff with guidance about how they wanted their individual needs met, although there was some occasions where there was a lack of clarity about where nurses recorded people's changing needs. People's care needs were not always reviewed and updated in consultation with the person. People did not have access to many activities and pastimes in accordance with their individual interests and preferences, and we did not see staff having time to support people with these pastimes. People knew who to speak with if they had any concerns and the provider responded to complaints received.

The provider had introduced systems for the assessment and monitoring of the quality of the service, but these were not robust enough to ensure risks to people's safety and welfare were identified and responded to. There was improvement in the systems in place to gain people's views on the service. People and staff told us they found the manager and other senior staff approachable although some people said they did not see the manager very often. The manager told us they were trying to resolve some issues with poor staff relationships and some staff were concerned about morale. Some staff said they felt well supported and were positive about the changes the provider was making.

The manager had not always notified CQC of events they were required to by law.

We found the provider was not meeting the requirements of the law in regard to ensuring people were kept safe. We found the service was not well led. Measures identified to ensure people were safe when transferred with the use of lifting sings had not ensured they were safe. Systems for the management of the service were not robust to ensure risks to people were addressed.

We found two breaches of legal regulations. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Most people said they felt safe but we found they had not always been protected against the risk of avoidable injuries. Moving and handling practices were unsafe. Staff could identify signs of abuse, but these concerns were not always escalated appropriately. People said they sometimes had to wait for assistance from staff. People told us they were happy with how their medicines were given to them, but there was room for some improvement to ensure medicines management was more effective.

Is the service effective?

Requires improvement

The service was not consistently effective

People's nutritional needs were monitored but risks to those people that had poor fluid intake were not always escalated until we raised this with staff. People's health care needs were not consistently promoted. People told us that they were mostly confident in staff but felt some were more skilled and competent than others. The provider understood how people's rights were to be promoted, and their best interests considered. People had a choice of diet, and felt the food they received was satisfactory.

Is the service caring?

Requires improvement

The service was not consistently caring.

People told us staff were caring but there were occasions where people's privacy and dignity were not respected by staff. People were not always shown respect by staff. People's independence was promoted.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's specific needs and preferences were not always responded to by staff. People were not always able to follow their chosen interests and lifestyles as staff did not always support them with these. People felt able to complain and the provider took concerns seriously and worked to address these to their satisfaction.

Is the service well-led?

Inadequate

The service was not well led.

Some of the systems used to capture and review people's experiences and to monitor the quality of the service had improved, but they were still not robust

Summary of findings

enough to ensure risks to people were escalated, monitored and responded to. People told us the manager was approachable but some said they were not always visible in the service. There were still issues relating to the culture of the service that the manager was working to address.

Parkfields Nursing 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 18 and 19 November 2015. We also inspected the service on 12 January 2016. The inspection was unannounced.

The inspection team consisted of one inspector, one pharmacist inspector, a specialist advisor (who was a nurse) and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements. We also spoke with the local authority and a health care professional about their views of the service. We received concerns that a person had received an alleged avoidable injury following our first visit to the service in November 2015. Due to this information of concern we continued the inspection for an additional day in January 2016. This was to gather further information about the injury and to see if other people living at the service were safe.

During the first two days of inspection in November 2015 we spoke with nine people who lived at the home, four visitors, the manager, deputy manager, two nurses, seven care staff, one laundry assistant, one maintenance person and a cook. We spoke with two visiting health care professionals. We also spent time looking to see how people were cared for and supported by staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at eight people's care records (including six people's medication administration records) and other records related to the management of the service for example audits of medicines, action plans and staff meeting records.

On the third day of inspection in January 2016 we spoke with two people, the manager, one nurse, six care staff, one administrator and the maintenance person. We also looked at records relating to the assessment of risks relating to the safe movement of people with equipment which included ten people's care records. We also looked at records for the servicing of equipment used to assist with people's movement.

Inadequate

Is the service safe?

Our findings

We received information of concern that concluded a person had sustained a serious injury that may have been avoidable due to use of the wrong equipment, namely a toileting sling, when lifting the person for general transfers. Following an analysis carried out by a health care professional we were informed that it was very possible, although not conclusive that the use of an incorrect lifting sling led to this person's injury. Staff we spoke with during our inspection confirmed that around the time the person was injured they were using a toileting sling which was not safe for use for this person. This showed that the provider had not taken appropriate action to ensure people were safe and that appropriate equipment was used by staff when moving and handling people.This showed that the provider had not taken appropriate action to ensure people were safe and that appropriate equipment was used by staff when moving and handling people.

We looked to see if the provider had made improvements to their moving and handling practices to ensure people's safety and mitigate the risks to people as much as possible. We found that contrary to manufacturer's guidance, the provider was still using toileting slings for people's transfers where they would present a risk to the person.Toileting slings give a greater degree of access for the means of toileting people, but very little support. This means they should only be used to assist people with toileting needs and not for general transfers. Staff we spoke with confirmed toileting slings were used for all transfers by hoist for eight people and showed us the toileting slings they were using. The manufacturer of the slings used by the provider stated toileting design slings are only to be used for those who are fully co-operative and with good upper strength and general sitting ability. They also state they are not suitable for lightweight, very frail, small individuals unless they have strength. Based on the assessments we saw for people using these toileting slings, these would not have been appropriate and placed people at risk of injury due to their continued use. For example, they were being used for people with limited upper body strength and those living with dementia. The provider had failed to ensure that care and treatment was provided in a safe way and failed to mitigate against the continued risk of injury caused by staff using toileting slings inappropriately.

We checked people's risk assessments and these did not always identify the slings that staff told us they were using to transfer people. In addition, we saw some risk assessments were not fully completed in that they did not clarify what people's physical ability was and how this may impact on use of a sling. For example, whether they had use of their arms and sufficient upper body strength. Without clear guidance in people's assessments there was a risk that the wrong type of sling for the individual, or for the specific task may result in inadequate support and therefore present an increased risk of the person sustaining an injury. The risks to people's health and safety during moving and handling transfers had not been assessed robustly, despite the provider's knowledge that a serious injury to a person previously, was likely to have been caused by the use of inappropriate moving and handling practices.

We found a person had sustained repeated bruising, this was reported to the manager and social services by their relative. Staff thought this had been caused by a bed rail although this was not conclusive. The person's risk assessment stated that protective covers were to be fitted over their bedrails to prevent injury. We found bed rail covers/protective wedges in place in the person's room, but one of these was loose. The person's care records said they moved while asleep with the area of bruising consistent with contact with the exposed bedrail. Action had not been taken despite reoccurrence of the injuries until we made the manager aware of our concerns. We found on the final day of our inspection that steps had been taken to prevent the person sustaining further bruising, with no further bruises reported. However until we raised this matter the provider's systems for minimising and mitigating risk had not been effective despite the relative raising their concerns.

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

At our previous inspection in June 2015 we found the provider was not meeting the law by ensuring people's medicines were managed in a way that ensured people were safe. The provider sent us an action plan after that inspection telling us about improvements they were

Is the service safe?

making to address this. We found the provider had addressed the breach of the regulation but further improvement was needed to ensure people's medicines were managed safely.

People we spoke with were satisfied with how their medicines were managed. We looked at six people's Medicine Administration records (MAR) and care plans to check people received their medicines as prescribed. The provider had made a number of improvements which included for example ensuring medicines were stored securely and medicines were kept at the correct temperatures, including those refrigerated. We did find that insulin for people living with diabetes was stored in the fridge and not at room temperature in accordance to the manufacturer's specifications. If a person is given cold insulin this can be painful. Nurses were aware of this and said they did not administer 'cold' insulin. They confirmed they would ensure insulin in use was stored at room temperature with the last date of use recorded to ensure people's insulin was given safely and in a way that minimised discomfort to the person.

We found topical medicines (creams) in MARs were not always signed as administered by care staff. A member of care staff confirmed creams were not always documented when administered. These creams may be important for ensuring the healthy condition of people's skin. We heard from a health care professional there had been a reduction in the occurrence of wounds referred to them since our last inspection, and before this inspection commenced which indicated staff were applying creams to people's skin where there may be a risk of, for example, pressure ulcers. We found comprehensive 'as required' protocols were not always in place so as to ensure staff were informed as to how people should receive this type of medicine safely. The manager said they would carry out more robust monitoring to ensure creams were recorded when administered. This would be important to ensure the health of people's skin is maintained through the correct and regular application of prescribed creams.

One person told us, "I feel very safe here". Another person said, "I have no problems at all" and a third person told us, "I am never worried about being safe". People knew how to raise concerns if they felt unsafe, with information from the Local Safeguarding Authority (LSA) available in the service. A professional from the LSA had made us aware of concerns prior to our inspection that while brought to their attention had not been reported as safeguarding alerts. This meant that while people said they felt safe, safeguarding concerns had not always been escalated appropriately. Staff were however able to describe what abuse may look like and how they should escalate concerns. Some concerns were raised with us by a person which we reported to the manager with their permission. The person said they had not shared these concerns previously although did not say why. The manager confirmed a few days later the person raised allegations which they told us they would investigate. When discussed with us the manager had not been aware these allegations of abuse should be reported to the LSA and the lead authority for investigating allegations of abuse. Although the manager did refer these allegations to the LSA, they were not aware of their responsibilities in this area until we addressed this with them.

People told us they had to wait for help from staff at times. One person said, "When I want the commode I have to wait. I always think if they don't hurry up I shall have an accident but I've never had any accidents". A second person said, "I've always been lucky, they [staff] have always come in time". A third person said, "They [staff] seem rushed to me especially first thing in the morning, they never have time". Another person said,"You have to wait". A visitor told us that while their relative was happy at the service there had been occasions when they visited where staff were not available. Some staff said staffing levels could be better although they said people were not unsafe as a result, just that people may have to wait for help at times. Other staff said staffing levels were satisfactory; it was the flexibility of staff that made teamwork difficult. This they said meant they did not work effectively as a team, for example there were days people did not get up when they wanted. The manager said staff numbers had not reduced since our last inspection although the number of people living at the service had. Despite this we did see occasions where people had to wait for assistance from staff, this not to the extent that people were put at risk though. We saw staff maintained their presence in communal rooms people were using and in most instances responded to people's requests in a reasonable time, although much of the staff interaction was task focussed and not person centred. This showed there were enough staff to keep people safe but consideration as to how staff were deployed was needed to improve the timeliness of their responses to people's needs at times.

Inadequate

Is the service safe?

The provider had systems in place for recruitment of staff that were robust and made sure that the right staff were recruited to keep people safe. We saw that checks, for example Disclosure and Barring checks (DBS), were carried out for new staff. DBS checks include criminal record and barring list checks for persons whose role is to provide any form of care or supervision.

Requires improvement

Is the service effective?

Our findings

At our previous inspection in June 2015 we found the provider had not always met the requirements of the law by involving people in making decisions about their care. The provider had not ensured that people's consent had been sought in respect of how their medicines were managed. The provider sent us an action plan telling us about improvements they were to make to address this breach of regulations. We found at this inspection the provider had made improvements in accordance with their action plan and were now meeting this requirement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. The manager and staff had an understanding of how they should consider people's consent to care. People who had not consented to the service managing their medicines at the last inspection, confirmed this had now been sought by staff and given. One person told us, the staff "Don't stop me doing anything I like" and other people we spoke with told us they were able to make decisions. We saw occasions where staff considered how to gain people's consent when they provided care, explained to people what they were doing and asked if people agreed. For example, staff explained to people how they were going to assist them, and did not proceed until the person agreed, or showed acceptance through eye contact or facial expression. We looked at people's records and saw that there were assessments of people's capacity in place, although these were not always completed. The manager told us that they were in the process of updating people's records which included MCA assessments when appropriate. We spoke with a nurse who understood how these would help identify what decisions a person had capacity to make, and when they may need support from other professionals to make decisions in people's best interests when they did not have capacity. The manager showed us that they had made referral to other professionals where decisions may be needed to keep the person safe, where a person lacked capacity. This showed that people's consent was considered and staff had an awareness of the principles of the MCA and what action they should take

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 are called the Deprivation of Liberty Safeguards (DoLS). There was one person who was subject to a DoLS at the time of our inspection and we saw that conditions on the authorisation to deprive the person of their liberty were being met.

We looked at how the service monitored people at risk of poor food and fluid intake. We found occasions where staff had documented people were taking less fluid than needed to maintain their health. We saw nurses used a recognised tool to calculate the amount of fluid a person should drink per day to maintain their health, but when some people had not drank this amount over a number of days concerns had not been escalated to the management. We found two people' s care records showed they had taken significantly less fluid than needed on a number of days. Although one of these people had been referred to their G.P for weight loss, no concerns had been raised about their poor fluid intake. We spoke with the manager and a nurse about this and they said these concerns had not been escalated to them although the expectation was that staff should escalate concerns of this nature. Concerns about staff not escalating people's poor fluid intake had been raised by the manager with the staff team at a meeting in October 2015 but during our inspection in November 2015 we found this issue had still not been addressed. When we visited the service again in January 2016 we saw that nurses were better identifying when people had limited fluids so that risks were recognised and responded to. This showed that improvements had taken place on the third day of our inspection. The manager told us they would ensure these systems were continued to ensure people not having enough to drink were referred to external health professionals where appropriate.

People we spoke with told us they were able to drink plenty. One person told us, "There are jugs of juice" around the service (as we saw) and they said staff encouraged

Is the service effective?

people that were unwell with fluids saying, "They [staff] will persevere until they [the person] do drink". We also saw that some staff took time to encourage people to drink. Another person said, "There is plenty to drink".

People told us the food they received was satisfactory and they always had a choice of food. One person told us, "The food isn't too bad, there's plenty of food, and I'm quite satisfied with the food". Another person said, "The food here is nice". We spoke with a relative who told us there was, "A good choice of foods". We saw that people were offered different options before and during meal times, and were there was an identified need for people to have, for example soft diets these were available and presented in a way that made them more appealing. We saw that staff assisted people appropriately with their meals but there were occasions were we saw some people had to wait for assistance from staff to help them eat, this as staff were assisting other people. This meant that while people were satisfied with the food they were offered, there was delay in some people having assistance with their meals.

People said they were able to see external health care professionals when needed. One person said, "I feel more secure living here than at home as staff know what to do if I am unwell". Another person said, "When I was unwell I spoke to the nurses and they were here straight away". A third person said, "I see a doctor every week". We saw that people who lived with diabetes had their blood glucose recorded daily and we saw good protocols and plans of what staff should do if results went beyond safe acceptable limits. We saw records of foot care by the chiropodist. One person living with diabetes told us, "I saw the chiropodist. I had them [toe nails] done a fortnight ago". One person's diabetes eye screening was however overdue, meaning there was a delay in monitoring any risks to their sight due to their living with diabetes. This showed there were some delays in promoting people's healthcare

People expressed mixed views about staff skills in providing good care. One person told us, "They look after me well here". Another person said", "I am very happy with the care" although a third person said, "Some of them know what they are doing. They are supposed to be trained. Some are better than others. The more experienced ones are better". One staff member said, "Quite pleased with the training, there is more I want to do and put in for [further training] with support to do". Another staff member said, "Training's ok". A third said that while they needed training this was planned for the near future. Newer staff had differing views of the induction they had, one saying after a brief introduction they were, "Chucked on the floor", although they, and other staff were positive about the support from the manager. Newer staff told us they were completing their 'care certificate'. The care certificate is awarded to care staff upon their being able to prove they meet certain national standards of competence. The manager told us they were monitoring and providing staff with training, and they felt this was important in improving staff skills. The manager acknowledged and identified areas where staff needed training to improve their knowledge and skills and said they would continue to update staff training and induction. For example staff, while aware of the need to check people's skin, still needed better awareness of what people's skin condition may tell them. The manager had identified this learning need and was arranging for care staff to participate in appropriate training to help them identify when people's skin was at risk. This indicated that staff were supported with training, but there were occasions where they did not demonstrate these skills in practice.

Requires improvement

Is the service caring?

Our findings

We found mixed approaches to interaction with people from the staff team. People told us about and we saw occasions where staff interacted positively with regard to people's well-being, for example by offering choices. However, staff practices were inconsistent. For example, we saw a person had fallen asleep and they had a runny nose. We asked a staff member if the person was alright. The staff member woke the person up and after asking them if they were sleepy wiped the person's nose without explaining to them why they were doing this. We also saw occasions where staff did not show people respect. For example, we saw one person trying to communicate with a member of the catering staff; the member of staff turned their back on the person and rolled their eyes. The person told us in their first language that they wanted to leave the room. While the member of staff told us that they did not understand the person's language, they made no attempt to find a member of staff that could so the person could be reassured. We saw another occasion where a staff member spoke about a person in front of them in a derogatory manner with reference to the person being, "In one of their moods".

We saw staff give a person a drink following a conversation. After this the person, who was visually impaired, was under the impression that the staff member was still in the room and they continued the conversation. They were seen to wait for a response after speaking a number of times. When they finished their drink they put their arm out to pass the cup to the staff member saying, "Nurse, can you take this now?" The staff member had not told the person they were leaving the room and we intervened and took the cup from the person. When the member of staff returned to record how much the person had drunk they did not speak to the person. These examples showed there were occasions where staff did not promote people's dignity, recognise people's communication needs and did not show respect or a caring attitude.

People were helped to dress in accordance with their preferences. We saw some people's choices reflected those that were identified as their preferred attire in their care plans. We saw staff helped people to change their clothing when they accidently spilt food or drink and this was carried out sensitively. We saw some people's finger nails had not been cleaned and some were quite long, although one person said they preferred them this length. The manager told us that one person would only let a particular staff member cut and clean their nails, this confirmed by the person when we spoke with them. The manager said they would ensure the staff member was made aware when next on duty.

People who used the service and other people who had contact with the service were positive about the caring attitude of the staff. One person told us, "Yes, they are kind and respectful". Another person said, "Some [staff] are alright, some aren't. I get on well with most of them". A third person said, "Yeah, they are used to me, I get on with them all". We did see some examples of staff providing care in a way that was considerate and caring. We saw some staff had a good relationship with some people and conversation between they led to smiles and laughter. One person told us, "They [staff] don't rush me when they are caring for me".

We saw that people's privacy was not consistently promoted. We saw some staff enter people's room without first knocking to gain permission. Other staff we saw did knock people's doors before entry. One person told us, "They [staff] knock on my door". We saw staff did promote people's privacy when providing care, for example when people were assisted to transfer from chair to wheelchair they consistently used screens to promote their privacy. One person told us that when staff provided care, "They closed the door and curtains". Some people told us they liked to spend time in their rooms and this was their preference, this respected by staff. One person who chose to stop in their room told us, "They [staff] know that I like my door open because it's too hot and I have my fan on too. They knock on my door".

We saw that staff promoted people's independence, for example where people were able to assist themselves we saw staff encouraged them to do so, for example using equipment to help them stand rather than hoists. One person told us they had freedom of movement around the service. Where there were risks to people, for example from falling we saw steps were taken to minimise the risks without unduly restricting people's independence or choice. Where people were able to walk independently we saw staff did not take their independence away from them. One person told us, "The [staff] help me get up; I stand on one leg and move around". Another person told us they were able to be independent.

Requires improvement

Is the service caring?

There was no restriction as to when people's relatives or friends could visit them. People told us their relatives visited us when they wanted them to this confirmed by one person who told us, "My daughters visit me almost every day". Visitors told us they were able to come to the home at times convenient to them and the person living there. We saw that people could have privacy with their visitors if they wished, for example in the person's bedroom.

Requires improvement

Is the service responsive?

Our findings

One person told us about a activities organiser that came in to do planned activity sessions but these were for limited periods and there were no activities on Wednesdays, Thursdays or the weekend. They added that they were able to occupy themselves and they were happy with how they spent their time. Another person told us, "I have the activities that the woman does and I have my sewing. I have my books and I talk to carers". One person said, "I only sit here, that's my choice" but told us, "I have the T.V. and radio. I used to love reading books". We asked if they had been offered audio books and they said, "I have never had audio books, who would change the tapes, I can't ask for special treatment". A relative told us a person, "Doesn't do activities, [they] prefer to stay in their room". We saw people were offered limited opportunities for occupation beyond television, radio and that provided by visitors, although there was one planned activity session with an external organiser on the last day of our inspection. We asked the manager how people were provided with opportunities to follow their chosen pastimes and they acknowledged this was an area where the service needed to improve. We did hear a comment from a relative that the staff had organised a, "Lovely party" for one person's birthday. This showed the provider did not always enable people to have involvement in pastimes that they found meaningful.

We saw occasions where staff did not respond to people's specific needs or preferences. Most people we saw were comfortable with the forms of address staff used when talking to them, but we did see person of Asian heritage looked anxious when addressed by their first name, and not by a title that would usually be used to show them respect. The member of the inspection team hearing this was able to communicate with the person in their first language. We spoke with the staff member who used the person's first name and they were unaware of why addressing a person of Asian heritage by their first name may cause offence. We spoke with the manager and they reassured us that staff that were able to communicate with the person in their language had asked the person if they were comfortable being addressed by their first name. We spent some time with a person who communicated using a form of sign language. The manager told us how they had looked to use a recognised sign language technique for this person but they told us this had not been successful. We discussed how the manager may be able to develop communication between people and staff with use of the person's individual methods of expression, so as to enhance their involvement in planning their care and making daily choices.

People we spoke with told us they had been involved in planning their care. One person said,"They [staff] did (care plan), seems like a long time ago. Time is so ongoing. I think something has happened a couple of days ago but it was this morning". Another person said, "I've done two or three care plans. I had this last one done with the family". A third person told us that they had discussed how their care was planned and they had been involved in discussions around this to their satisfaction. People told us that they were usually satisfied with the care they received and this reflected what they wanted but there was some inconsistency, this thought by people to due to the turnover of staff. One relative told us, "You get 100% for three months or weeks, then 50% instead of getting 75% all the time, surely that is better". Another person said, "They [staff] can get you get anything you want if you tell them".

We saw that people's care plans were usually reviewed on a monthly basis, this confirmed by nurses we spoke with. We saw that these reviews in most instances identified changes in people's needs and action was taken to involve appropriate health care professionals where needed, although there were exceptions where concerns had not been escalated for example in respect of some people's poor fluid intake. On the last day of our inspection we discussed inaccuracies in some people's care plans and assessments with a nurse, who subsequently changed information in the person's records as we discussed these issues with them. This showed that changes to people care plans and records were not consistently reviewed and updated with the involvement of people to whose care they related.

Some people told us that the provider sought their views, although other people could not recall if they did. One person said, "They never asked me about meetings or questionnaires, at least I don't think so". Another person said, "I don't think I was here when the meeting [with people] was on but my daughter went". Another person said, "No I haven't done any questionnaires, I think they do have resident's meeting but I don't go ".The manager told us that they had organised a meeting for people and relatives although this was only attended by one relative. We saw minutes of the meeting that showed the manager

Requires improvement

Is the service responsive?

had a one to one discussion with the relative to discuss their views. One person told us, "If I could have a motorised wheelchair, if they could assess it and I could go out on my own, just close by. I've not mentioned it – I didn't think they'd be interested". We discussed this with the manager who confirmed it had not been raised previously. The manager informed us after our inspection that they had discussed this with the person and acted upon their wishes.

People we spoke with knew how to complain and we saw there was information about complaints available within the service. One person told us, "If I am not satisfied I'll say" another that, "I never had any need to complain". A third person said they would speak to the manager if there was a concern. A relative told us they had received written feedback when they had complained which included detail of the investigation and the outcome from this. The manager said they had promoted the service's complaints procedure by telling people and relatives how to make a complaint and they thought this had improved feedback they received on the service. We saw complaints received were logged and outcomes led to fed back to people, although we did hear from some people that they were not always satisfied with the outcome of the investigations, although had not wished to escalate their concerns at the time. We saw the manager had shared outcomes from complaints with staff in meetings to inform them of findings and what this meant for their practice.

Inadequate

Is the service well-led?

Our findings

There was not a registered manager for the service at the time of our inspection. The registered manager is vital in helping to make sure people receive services that are safe, effective, caring, responsive and well-led. The last registered manager cancelled their registration on 31 March 2015. The provider recruited another manager who took up their position in June 2015. The provider is required by the law to have a registered manager in place and we have now received an application for registration from this manager who has been registered since the inspection.

At our previous inspection in June 2015 we found the provider had not ensured that systems were robust enough to ensure that risks relating to the health, safety and welfare of service users were responded to. The provider sent us an action plan after that inspection telling us about improvements they were to make to address this breach of regulations. We found at this inspection the provider still needed to make further improvements and had continued to breach this regulation.

We looked at the provider's systems for monitoring and responding to risks in the service. We saw these measured risks based on people's health, for example the number of people with pressure ulcers, falls and weight loss which would allow the provider to gain an oversight of risks to individuals that may require further scrutiny or action. The provider was also using a quality assurance review tool to highlight areas needing improvement and there were dates for these actions to be completed by. Although these monitoring systems were in place and being used we found these systems to be ineffective as they had failed to address and improve the quality and safety of services being provided. For example, despite the provider being aware of an injury that had likely been sustained by poor moving and handling practices, they had failed to learn from this incident and assess, monitor and take steps to prevent the risk of any further injuries being caused. They had not ensured that staff were properly communicated with or monitored moving and handling practices within the service so as to assure themselves that appropriate action had been taken. As a result, staff continued to place people at risk of injury.

The provider had completed an action plan drawn up by commissioners where the expectation was there would be a nurse trained in manual handling and use of slings and hoists. There was also an expectation these assessments would be checked by a competent manual handling instructor. The provider's identified actions were that senior staff would identify the slings people were to use without any action to ensure a competent manual handling instructor was involved. The provider's action plan had failed to protect people from the use of inappropriate equipment.

Although the provider had other quality assurance systems in place to recognise and respond to risk, these were often ineffective. This was because the concerns these systems recorded and identified were not always acted on or escalated by the staff team to the manager or provider. For example, the problem with an exposed bedrail potentially causing continued bruising had been noted but not escalated for action. Likewise, recording systems for identifying the risk to people of poor fluid intake were not effective because staff did not recognise the need to escalate these issues to the manager or provider.

We found that systems to ensure the service was clean and infection control was promoted were not always effective. Despite audits we found some bedroom carpets were sticky underfoot and some rooms were dirty, for example we found faeces on a bedrail and dried food on mattresses. These issues were raised with manager who ensured they were addressed immediately; however they had not been recognised until our inspection. The provider's audits had not identified these issues and ensured a response. We also found that a single use syringe was used for flushing a person's feeding tube, on a number of occasions despite a visiting infection control specialist confirming these should be disposed of after use. This again showed that risks to people were not always identified and acted upon by the provider.

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

Roles and responsibilities within the staff team were not always clearly defined and there was a lack of communication between the staff team. For example, we found the way some information was recorded meant that important information about people's care may not have been understood by all staff. One nurse recorded information about a person's care in a 'wound dressing' diary that the manager, deputy manager and other nurses had no knowledge of. This meant that some nurses and the

Is the service well-led?

manager did not have access to important information about this person's clinical care. The manager said this practice would be stopped immediately and they showed us a management folder for recording wound dressings which was to be commenced. The manager also said that they were currently introducing a new care recording system, this with the intent that all staff would be able to locate the records they needed so they knew what care and support people needed.

We found that the provider had not consistently met their legal obligations in submitting notifications to CQC. We were made aware of allegations of abuse that the manager had been aware of in October 2015 that were not reported to us as required by law. We raised our concerns with the manager about this and have received notifications since this time.

The manager told us that following changes in the management team, specific nursing staff had been delegated key areas of responsibility for example clinical leadership and medicines. Nurses confirmed this and their lead responsibilities. People we spoke with were positive about the manager. One person said, "[The manager] is much better to talk to" but did also say the service, "Picks up and slides down again". Other people knew who the manager was but said they did not see them much. One person said about the service, "It might be slightly better, not that much has changed", another that, "It's better than before. It's gone up a bit but it doesn't stay up. It should run much more smoothly". The manager told us that they rarely went onto 'the floor' because they wanted the nurses to be in charge of care and felt their presence may intimidate the nurses and care staff. However this meant that the manager was reliant on staff raising any concerns around care practices to them, when we had found issues of concern had not always been escalated.

The manager said when taking up their post in June 2015 they had concerns that there was a culture of bullying and lack of respect between the staff team. They said that changes they were trying to implement were taking time to work but they were endeavouring to support staff and improve relationships. They told us they were improving one to one supervision with staff, having more regular meetings and using exit interviews for staff that were leaving. Staff told us they received support from the manager, although a staff member said they felt staff morale was low due to friction between care staff and nurses. Some staff said the manager was making positive changes.

Staff told us they felt able to raise concerns and said they would feel able to contact the provider or external agencies and 'whistle blow' if needed. A whistle-blower is a person who exposes any kind of information or activity that is deemed illegal, dishonest, or not correct within an organisation that is either private or public. Staff told us they would whistle blow on poor practice, one telling us they felt, "I would get the support from the manager" if they did so.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not robust enough to ensure that risks relating to the health, safety and welfare of service users were consistently addressed. Regulation 17(1)(2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider has not ensured that care and treatment is being provided in a safe way for people because they have not ensured moving handling procedures have been carried out safely and that people have been transferred using appropriate equipment. In addition, the provider had failed to ensure appropriate risk assessments have been carried out by suitably competent individuals. Regulation 12 (1)