Healthcare Homes (LSC) Limited

Handford House Care Home

Inspection report

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Date of inspection visit:
26 April 2017
02 May 2017

Date of publication:
12 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Handford House provides accommodation and nursing and personal care for up to 52 older people. There were 51 people living in the home on the first day of our inspection.

This inspection took place on 26 April and 2 May 2017 and was unannounced on both days.

A registered manager was in post at the time of our 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.

There was a change of provider at the home during April 2016 when the current provider Healthcare Homes Ltd took over the running of the home.

There were insufficient numbers of staff on duty. Staff were not always deployed effectively in order that they could meet people's needs effectively. Staff were not always well supported. They did not receive any formal supervision or appraisal.

All medicines were administered by staff who were trained to do so but some aspects of medicines management needed improvement.

Care records did not demonstrate people's involvement in decision making. Mental capacity assessments were not completed and best interest meetings had not always taken place for people who lacked capacity.

Care plans were not all up to date; the information within them was not always current. We could not be confident that people always received the care and support they needed.

People received support from staff that were mainly kind and caring. However, people were not always treated with dignity and respect because staff were task focussed and care took place in a manner that was not centred on people as individuals and was at times hurried.

There was a quality assurance audit in place however the system was not always effective because issues identified at the inspection had not been recognised during the monitoring and auditing process.

Staff had an understanding of abuse and safeguarding procedures. They were aware of how to report abuse as well as an awareness of how to report safeguarding concerns outside of the service. Staff undertook safeguarding training providing them with knowledge to protect people from the risk of harm.

Risk assessments in relation to people, such as mobility, skin integrity and choking were in place and identified control measures to minimise risk.

Referrals were made to external healthcare professionals and we saw involvement from district nurses, chiropody, dentists and GPs.

We found the home was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires Improvement

The service was not always safe.

People's medicines were stored safely but not managed effectively which placed people at risk of harm.

There was insufficient staff on duty to meet people's needs. Staff were not effectively deployed and available at all times to meet people's care needs.

Safeguarding procedures were in place and they were supported by staff who understood how to recognise and report any signs of abuse.

Is the service effective?

Requires Improvement

The service was not always effective

The registered provider did not have adequate systems in place to assess people's ability to make their own decisions under the Mental Capacity Act 2005 (MCA).

People were supported by staff that did not have regular supervision or appraisal.

People provided mixed feedback about the quality of the food in the home.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst some staff treated people in a kind and caring manner this was not always demonstrated by others.

People's care was not always planned and provided in a personalised, respectful manner.

Staff did not always have time to spend with people and were

often task orientated.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always up to date or robustly reviewed.

Activities staff were employed, however people and relatives told us there was a lack of stimulation and person centred activities provided.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality monitoring arrangements were not fully effective. They had not identified the concerns and shortfalls that we identified at this inspection.

Systems were in place to assess, monitor and improve the service but these were not being operated effectively as they had not prevented the several breaches of regulation we identified from occurring.

Handford House 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 April and 2 May 2017 and was unannounced on both days. The inspection team consisted of two inspectors and an expert by experience on the first day and two inspectors on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about

Before the inspection, we requested that the provider complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was received from the provider. We also reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us. We also requested feedback from the local authority quality assurance team

During the inspection we spoke with 14 people living at the service and eight relatives. We spoke with the registered manager, the regional manager and three nurses. We also spoke with one senior care staff, five care workers and a member of the catering team.

We reviewed seven people's care records, daily records and health charts. We also viewed records relating to staff such as training information. We reviewed medicine records for eight people, as well as records relating to the management of the service.

We looked around the building and spent time in the communal areas on both floors at the home. 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.

Requires Improvement

Is the service safe?

Our findings

We looked at the way people's medicines were managed. One person told us, "I don't get my medication on time, my symptoms increase." We found some medicines were not being managed safely and robustly and medicine stocks were not always accounted for. During our audit of medicines we compared medication records against quantities of medicines available for administration. We found discrepancies which meant we could not be assured that people were receiving their medicines as the prescriber intended. We asked some of the nurses, who were responsible for the administration of the medicines, about the unaccounted for medicines but they were unable to identify why the discrepancies had occurred.

We carried out a random sample audit of supplied medicines dispensed to people. We found there were numerous unexplained gaps on the medication administration record (MAR) charts. Some medicines required two staff to administer them and sign to state administration. We found that there were not always two signatures present. In other instances where only one signature was required, we also found a number of unexplained gaps. Nursing staff could not account for why this was and told us that improvements were needed to the auditing of medicines within the home to ensure accuracy around monitoring the stocks of medicines and recording.

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

We saw that the temperature of the medicines room and fridge were recorded daily and were within acceptable limits. Arrangements for the administration of PRN (when needed) medicines helped protect people from the unnecessary use of medicines. People had PRN protocols in place which informed staff when to administer their medicines. PRN protocols are important because they inform staff of the signs they would need to look for to show a person may require the medicine or the desired effect the medicine would have.

Although most people we spoke with said that they felt safe living at Handford House some people also told us there were not enough staff to meet their needs. Some people gave us examples where their needs were not being met in a timely way and the effect this had on them. One person said, "They used to come and chat with me, sort my clothes out, now I daren't ask because they won't have time". Another person told us, ""I don't think much of them, I push my buzzer for help and it can be 20 minutes." A third person said, "You must be joking if you think they [Staff] have time to get to know you". Another person commented, ""Some days they are still getting people up at 1pm in the afternoon"

We spoke with people's relatives as part of our inspection. One relative said, "I am concerned about my [relatives] care, they [Handford House] seem so short of staff. On Sunday when visiting the call bells were regularly going off and not being answered for what seemed ages, I only saw one member of staff all the time I was here."

We asked staff if they felt there were enough of them on duty to meet people's needs in a timely manner.

One member of staff told us, "Yes I think so usually. It depends what staff are on duty, it gets hard, if we have agency to cover for regular staff." Another member of staff told us, "I do not think we have enough staff, everyone needs so much care from us with everything, feeding, dressing and washing." A third member of staff said, "Most of the time we are so busy here I don't even get chance to eat my lunch. It is so demanding and some people are so poorly and at the end of their lives. Everything takes so long. We need more staff."

We were concerned about the impact that the reported lack of permanent staff in some areas of the home was having on people. People and staff told us, and rota's confirmed, that a lot of agency staff were used to cover vacant care hours. The use of agency staff to cover vacant posts and uncovered shifts amounted to a large number of hours each week. We observed some poor practice in terms of infection control and interaction with people by agency staff whilst they were working at the home. People told us they were not always comfortable with agency staff providing their care, especially where the same agency staff were not used and there was little continuity of care. One person said, ""I don't feel safe, not with strangers. I won't have any male carers. I don't think we should have so much agency, you don't trust them or know who they are." Another person said, "You do get a lot of changes of staff, not like when I first came. Some of the old staff are disappearing, which is a shame, we have a lot of agency".

During our observations we saw the staff were constantly busy and task focussed. Some people had complex care needs and as such required a lot of specific care which took staff considerable amounts of time. We saw the morning medicines administration round did not finish until approximately 11am, resulting in those people who required medicines again at lunch time not having a sufficient gap between. Nurses told us that the medicines round was so late as there was simply not enough staff or time for them to complete them earlier. Staff informed us that they were required to support people with any activities arranged but they were so busy with meeting people's care needs this rarely happened.

We observed during the first day of our visits there were five people sitting in one of the lounges. Three people were asleep and there was no communication between them. We commenced our observations at 10.15am. It was not until 10.45am that a member of staff entered the lounge. We noted when they did so they spoke to us but none of the people sitting in the lounge and left again. This meant the lounge was unattended by care staff for 30 minutes and during this time there were no staff checking upon peoples well-being, carrying out activities or offering drinks or snacks. On the second day of our visit we saw people were again also left for long periods of time without any interaction with staff.

We spoke with the registered manager about the dependency tool in place and whether this was effective. The registered manager told us that there were plans to increase the level of nursing staff on the ground floor as they had been told by staff of the challenges and had recognised that an increase of nursing staff was needed.

We found that there was an insufficient number of staff deployed and available and this impacted on the care and safety of people living at the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some systems in place to reduce the risk of people being harmed, however these weren't always effective. It was noted in several of the care records we viewed that people had been assessed as being at high risk of developing a pressure ulcer. We saw, however that these risks were not monitored with effective record keeping. Some of the actions required to mitigate these risks were for staff to regularly carry out personal care checks and re-position people every four hours. However, the records in relation to these people's care indicated that the required personal care checks and re-positioning had not always taken place. In one person's care records we noted that on 24 April 2017 that their repositioning records indicated

that the person was left for nine hours and 15 minutes between being moved during the day and left between repositioning for 10 hours and 20 minutes during the evening and into the next morning. On 21 April 2017 the same person had no recording that they were repositioned for 12 hours. We saw that this was an example of several people's records where their repositioning was not recorded. Staff we spoke with were aware of the people who required assistance with repositioning. However because of the gaps in record keeping they could not be assured that people were being repositioned as necessary in order to reduce the risk of a pressure ulcer developing.

Another person had moved bedrooms between the two different floors at the home. They had been assessed as needing a specialist diet however the risk associated with them not receiving the specified diet and what the diet constituted had not been communicated effectively between staff on the two floors. These actions placed the person at serious risk of harm. We spoke with the registered manager and deputy manager about this who informed us action had been taken to improve consistency and continuity of care by staff on the two floors.

We saw two staff using manual handling equipment to move a person from a wheelchair to a reclining chair. They spoke with the person clearly explaining what they were doing and asking for the persons consent and co-operation. The staff were clear upon which loops to use of the sling and this was in line with the person's plan of care.

We found that people were supported by staff who were knowledgeable about safeguarding people from the risk of abuse. Staff knew what procedures to follow if they suspected any type of abuse. Training records confirmed staff had received safeguarding training and there were policies and procedures in place in respect of safeguarding and whistleblowing to support staff. One staff member told us, "I am confident about the different types of abuse and what to do should I be concerned about anything." They went on to tell us about the different types of abuse and how they would respond appropriately. The registered provider was aware of their responsibility to report issues relating to safeguarding to the local authority and the Care Quality Commission.

Checks on the premises were undertaken by the maintenance worker. These included regular checks of the fire systems. Lifting equipment, gas, fire and electrical equipment were serviced in line with statutory requirements by external contractors. Personal Emergency Evacuation Plans (PEEPS) were in place for each person who used the service. These provided information on the support people required should they need to be evacuated in the event of an emergency.

We spoke with staff who had been recently recruited to the home. They told us about the recruitment process that the home had followed before permitting them to commence employment and support and care for people. The staff told us that they initially completed an application form, which recorded their employment and training history. They then described how they went through a selection process and that the provider ensured that the relevant checks were carried out to ensure staff were suitable to work with people. We found that the provider requested criminal records checks through the Government's Disclosure and Barring Service (DBS) as part of the recruitment process. The DBS helps employers ensure people they recruit are suitable to work with vulnerable people who use care and support services.

Infection control practice was observed to be poor in some areas of the home. We observed one staff member wearing the same disposable gloves during the disposal of soiled waste and then when returning to the persons bedroom. We also were concerned that appropriate methods were not always used to transport soiled linen as we observed care staff held soiled linen/clothes against their own clothes when carrying through to the laundry basket. Care and nursing staff did not wear uniforms and we observed on

several occasions they also did not always wear disposable aprons when handling soiled bedding or used continence products. One person told us, "I hate the fact that the staff don't wear uniforms. I think they should, so everyone knows who and what you are".

Requires Improvement

Is the service effective?

Our findings

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 is called the Deprivation of Liberty Safeguards (DoLS).

The sample of records we reviewed showed that there was an inconsistent approach to the application of the principles of the MCA at the service. Where people were assessed as lacking the capacity to make specific decisions, we found that a process of best interest decision making had not always been undertaken and recorded. We found that capacity assessments for specific decisions such as, for example, whether a person could consent to use bed rails were not detailed. There was no evidence to show how the people whose records we viewed had been supported to consent to or understand the decision to be made.

Staff had completed training in MCA. In discussions on the day of our visit they demonstrated a good understanding of the principles of the MCA and were clear about how they gained consent from people regarding care and support tasks. However practice did not always reflect the understanding of the legislation.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our visit we found that several DoLS applications had been made to the local authority in relation to people who lived at Handford House and these were awaiting an outcome. We could see that whilst they were awaiting authorisation, the least restrictive methods within their best interests were employed to keep people safe.

People we spoke with were not always sure that staff received the training they needed to provide them with the support they required. One person commented, "The staff that know what they were doing have left, at one point it was all agency and limited regular staff, they don't know anybody, you feel for them." Another person said, "Staff are okay individually, some are new and it's literally 'rabbit in the headlights', others are slow, you are clock watching as they are getting you up thinking 'come on'. I don't bother to have a shower as it takes too long".

Staff however told us they had received training to allow them to offer care and support to people living at the home and records confirmed this. New staff were required to undertake induction training, a period of shadowing and the Care Certificate. The Care Certificate is a nationally recognised study plan for people new to care to ensure they receive a broad range of training and support. One new member of staff told us they had recently started work at the service and had a good induction with support. They told us that they

were able to shadow other staff before working on their own.

Staff told us that they had not been receiving formal arranged supervision or an annual appraisal. They told us that whilst the nurses were supportive and helpful they did not have the opportunity to meet with their line manager on a regular basis to discuss their work role and development. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff or manager. Staff should receive appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their role. The registered manager and deputy manager told us they were aware that improvements were needed in this area and that this was something they were beginning to address.

We asked people using the service about the quality of food they received at the home. We received very mixed responses. On person said, "The food is lovely, you get a great choice. I have pureed but I don't mind. You get plenty to eat and drink." Another person said, "The food is surprisingly nice, not bad at all, very plain. We all used to have salt and pepper on the tables, now you have to go and find one. We have sauces, tartar, and tomato. If it is somebodies birthday they make a cake, they are very thoughtful. You do sometimes get bored of the same things though."

However other people were not complimentary. One person told us, "The food is diabolical, other people love all the stodge, and the veg are over cooked. It doesn't matter what I ask for, the standard doesn't improve, and I don't look forward to meal times. Sometimes you choose the day before, sometimes the menu is not even done so you don't have a clue what's going to come". Another person said, "I've been living on jelly and ice-cream. I can't eat meat and the pureed food is like dog food, they slop it on the plate, it's not presented well".

We observed the dining experience that people received on each of the two floors. The food appeared appetising and well presented. We observed that staff were very busy during the mealtime. One member of staff was with seven people in the dining room, trying to provide them with either assistance to eat where required or prompting. One person was provided with their meal on a specialist plate that was designed to stop the food falling from the plate, however the staff gave the person the plate the wrong way round which resulted in them losing their meal onto the table. When a member of staff was available to help, we saw the person smile to acknowledge the company and help. Another person was provided with their meal without it being cut up, they then proceeded to try and eat a large piece of meat whole.

We spoke with one of the two chefs who worked at the home. We found they were mostly knowledgeable about people's nutritional support needs such as specialist diets or those people who needed a soft diet and where people were at risk of choking. However information about people with specialist dietary requirements such as people at risk of choking was not always shared with them effectively. This meant that there was a risk of them providing and preparing the incorrect texture of food for people.

We looked at some people's nutritional records. We saw that one person had lost 3kgs in four months from December 2016 to April 2017. Whilst this persons weight was being monitored they did not have a daily food chart in place to accurately record their daily food intake.

Whilst we saw that there were drinks available in communal areas and in people's bedrooms there were no snacks that people could help themselves to at a time they pleased. This was particularly important where people were at an identified risk of weight loss. The registered manager told us that cake was served to people during the afternoon and at other times snacks were available however they were kept in the kitchenettes on each of the floors. Because these kitchenettes were locked when there were no staff present, this meant that people had to ask for food and could not help themselves. The registered manager told us

that they had identified this and had ordered some tables to put in communal areas where snacks could be placed. However in the meantime no action had been taken to enable people to access snacks freely. A member of staff told us that in the evening the staff would check upon how much people had eaten and drank during the day and offer snacks with supper and milkshake drinks.

People received support to keep them healthy. People's care plans included a record of visits that they had received from healthcare professionals, and their outcomes. People were able to access the appropriate healthcare support such as the dietician, GP and community nurse to meet their on-going health support needs. We saw records that demonstrated that appropriate referrals had been made when people required ongoing support with a health diagnosis.

Requires Improvement

Is the service caring?

Our findings

We asked people using the service about their experience of the care and support they received and received very mixed responses. One person who was approving of their care told us, "The staff are lovely, they help me wash and dress, good [staff], they are all nice." Another said, "The majority of carers are nothing short of pure angels, when I found out my [spouse] was unwell they were very supportive and helped me a lot".

Some people who were positive about their care described staff as kind but felt that they were short of time and too rushed to spend any quality time with them. One person said, "The carers are lovely, don't get me wrong. If I ask for anything they always do it but they [staff] don't really talk to us. Before everyone had a smile, they [staff] are run off their feet." Another person told us, "They are busy, but pretty good really, they look after you alright".

Several people were not complimentary about the care they received. One person told us, "I want to leave; the standard of care has gone downhill drastically, even since Christmas. Staff are leaving in droves, they don't feel listened to." Another said, "They [staff] are casual, uninterested. I think it's a very difficult job and they don't do it well. It's not a happy household [home]."

We saw there were missed opportunities for staff to engage and socialise with people who used the service. Some staff frequently moved people in their wheelchairs or armchair with wheels without talking to them or communicating what they were going to do.

People's privacy was not protected in all cases. Some staff knocked and sought permission before entering people's rooms however other staff were observed walking straight into people's rooms, whether the door was open or closed, without knocking. Some people ate their meals in their bedrooms. We observed one member of staff walk straight into a person's room without knocking on their door or saying a word to them. The member of staff then proceeded to help the person to eat their meal without speaking at all. Another person who had their meal in bed was helped with their drink using a straw which the member of staff removed from a finished drink that had been left in the persons room.

We also observed that some staff were respectful of people's privacy. They took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and providing as much encouragement to be independent as possible. A staff member told us, "I always offer choices. Many people can help themselves even if it only a little, they have a go."

We also observed some good relationships between people and staff. We noted one person became unsettled and upset. We observed a member of staff responded in a caring and patient manner and offered reassurance when needed. We also saw one member of staff taking time to encourage people to drink and to eat at meal times and to listen carefully to people when communicating with them.

When we spoke with staff individually they had a genuine regard for the people living at the home and they were able to tell us about the people in their care, including likes, dislikes and care needs. We also saw examples of staff being patient and demonstrating that they clearly had empathy for the people in their care.

We saw from the care plans we viewed that people and their relatives were involved in the initial assessment of their care needs. However there was little evidence of any further reviews involving people or their families. The home held a 'resident of the day' scheme, the aim of which was to promote person centred care planning and reviews. The scheme should have ensured that once a month each person would have a full care plan review however records we saw were partially completed and there were large sections blank.

Requires Improvement

Is the service responsive?

Our findings

Some people told us they received personalised care which was responsive to their needs. We asked people about whether they received the care that they wanted to have. One person told us, "I asked night staff not to check on me, waking me up, so now they don't". However another person wasn't as positive and said, "You tell one of them [care staff] something on a Monday and then on Wednesday you ask again and they know nothing about it. They will do something once but are not good at carrying things on, that's the change of staff."

However some people told us that they did not always receive care in a way which was responsive to them and how they wished to be cared for. One person said, "I wanted my hair brushed in a certain way, they told me 'so long as your hair is being brushed that's what matters' which upset me." Another person told us, "Certain things are written down, whether they happen is another thing." We observed some practices by some staff that did not indicate that people's dignity was always respected. One person told us that at times there were not enough staff to provide them with timely support to protect their dignity. We were told, "I don't wear a [continence product] and sometimes I'm desperate, I have wet the bed a few times".

There was a lack of any meaningful activity taking place in the home during the two days of our visits. We observed that people living at the home lacked meaningful occupation, other than visits from friends and relatives. On the second day some people did go in the home minibus, however there was no alternative activity for those people who remained at the home. Throughout the time of our inspection no music was played at any time on the upper floor, although the staff did sing with one person, when providing care to them and we saw in their care plan that they enjoyed singing.

People's routines during our visits were dominated by meals and personal care and the remainder of the time people were in their bedrooms or communal areas, watching TV or sleeping. People told us however that at other times there were occasional activities that they could choose to participate in however these were often not of their choosing or enjoyable. One person told us, "I don't go to the activities much. I've been to them but I'm not one to throw a bean bag". Another person said, "Last week we had singing, they played two songs and that was singing over and done with." A third person told us, "I'm frustrated as I can't see well anymore, I can't draw and paint. There is no one really to talk to. I don't find a lot of interest on the telly."

There were boards advertising activities that were available each day of the week. We saw that some of the activities were listed as being available during the evenings when the activities staff were not at the home. We were told that care staff undertook these activities with people, however when we asked staff they told us that this was not always the case and that often they were too busy providing care to facilitate activities as well. One relative we spoke with told us that they had not always seen the advertised activities available for people to participate in. One relative said, "My [family member] has been to a few things, I'm not sure they do what is on the board."

We spoke with the manager about the activities on offer for people. They had already recognised that improvements were needed and had identified the activities as an area for improvement.

We recommend that the home seeks advice about planning appropriate activities to engage people living with dementia. We will monitor progress on this and check on this at the next inspection.

Everyone had a care plan in place, some were recorded in the format of the previous provider and some had been changed to the current providers system. We found further improvement was needed to ensure care plans consistently reflected people's current care needs. We found a number of people's care plans were not completed in full, information was missing and there was no evidence that the provider included people in planning their care. People who could talk to us were not all clear about their care plan and whether one was in place. One person commented, "Somewhere here I have a care plan, not sure where."

Within the care plans there was information about the person, however this was often not fully completed. Staff recorded on a body map any marks or bruising that a person may have. However the action of what to do was not always recorded or when any intervention was completed. One person had 12 different body maps in their care plan that had been completed over a three month period. However none had been concluded with a plan of action by staff or any evidence of action being taken at the time.

We were concerned that the lack of clear and complete guidance within the care plans was a risk due to the high number of agency staff used within the home and the fact that they may not know people very well.

The staff we spoke with were not sure who and when the care plans were audited and updated. People who could talk to us about their care plans were also not sure about how these were reviewed.

These concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives were complimentary. One said, "I've asked them to take better care of [family members] eyes, they look better today so when you mention something they do it." Another relative commented, "One thing they have done in here is improved [family member], they are getting them up, they are eating. Staff all seem really nice and friendly".

We looked at the homes' complaints records. This showed that procedures were in place and could be followed if complaints were made. There was a policy that provided people who lived at the home and their relatives with information about how to raise any concerns and the process that would be followed. People and relatives we spoke with were aware that they could raise a concern; however they were not always sure that concerns would be dealt with appropriately. One person said, "I used to complain; now I don't bother because it goes nowhere. I have bought subjects up with the management, they say all the right words but nothing gets sorted, they don't exactly follow through." When we asked staff they were clear on how they would address any concerns raised by people or their families. One member of staff said, "I would refer anyone wishing to make a complaint to the senior person on duty to either resolve the problem or for it to be recorded in writing."

A relative told us, "I have no complaints my relative is being looked after very well here [Handford House]."

Requires Improvement

Is the service well-led?

Our findings

We found that the home had been through a period of significant change. As well as a recent change of manager there had also been a change of provider of the home during April 2016. From talking to people, their relatives and staff as well as our observations we recognised that the registered manager had a number of challenges at the home which they were trying to address.

Although there were systems in place to assess and monitor the way the service was run, we found that they had not identified or fully addressed all of the issues that we found during our visit.

Whilst staff were aware that some people were at risk of weight loss and pressure ulcers, we identified that the corresponding records and charts were not always completed. It was not clear who checked that nutritional records were in place and that these and repositioning charts were completed. The wellbeing of those people who required this support was dependent on staff to ensure they received adequate nutrition and pressure care. Accurate record keeping was an important part of these processes that was not always well managed. Despite there being a medicines audit process in place, these had failed to pick up the concerns we found with the safe management of people's medicines.

The registered manager told us that an annual review had not been carried out at the service. One person told us, "We don't get given feedback forms. We do have meetings, we used to have resident and relatives meetings but now that has changed, [registered manager] wants separate meetings but most residents can't contribute. We find out things, you hear a bit from one person, a bit from another, that's how you know what's going on".

We were told by the registered manager and regional manager that the home had a supply of feedback forms they accessed and sourced from an online website. We were told that relatives were encouraged to complete one of these to provide their comments on the home, the outcomes of which would be displayed on a website. This meant that there was no formal way in which the home was seeking people's opinions on the home and analysing them in order to review the service and plan for the future. The regional manager told us that they had plans to introduce at the home the providers system for seeking views however they had delayed doing so because of the number of changes that had recently taken place at the home.

People told us that there were limited opportunities for them to contribute to the running of the home and express their views. One person said, "We have had one resident meeting but I didn't feel comfortable going". We heard from the registered manager that they had attempted to hold meetings for people and their relatives however attendance had been very poor.

People, their relatives and staff we spoke with were mixed in their views about the management of the home. One person said, "Before it [the home] changed hands it was a lot better, so many unhappy people here, residents and staff." Another person commented, ""The manager is new, I think she's trying to improve it but lots of staff are leaving." Relatives also felt improvements were needed. One said, "Communication has not been the best, they [home management and staff] don't really update me when I come in."

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

The staff team told us they generally worked well as a team and were very supportive of each other so that people could rely upon receiving consistent support. The care staff considered they worked as a good team and found the nurses helpful and knowledgeable and demonstrated a caring attitude. Some staff were unhappy about recent changes made and was reflective of their comments to us.

We found the management team had an honest approach and were professional. They listened to the feedback we provided throughout the inspection and were receptive to our findings and keen to share their plans for developing the home further. We did see that some of the concerns we found during the inspection had started to be identified by the management team and were being dealt with. Improvements were needed to people's care plans and we could see that some work had been undertaken to commence this piece of work. However we also saw that whilst the management team recognised that improvements were needed to the monitoring of people's nutritional intake and repositioning for reducing the risk of pressure ulcers these had not been embedded effectively and consistently into practice. We concluded that due to the high care needs of people and the lack of appropriate staffing levels there was a lack of nursing oversight on the floors.

Records, and our discussions with the service manager, showed us that notifications had been sent to the Care Quality Commission (CQC) as required. A notification is information about important events that the provider is required by law to notify us about. This showed us that the home manager was aware of their role and responsibilities in this area.

People benefited from staff that understood and were confident about using the provider's whistleblowing procedure. There was a whistleblowing policy in place and staff were aware of it. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. They can do this anonymously if they choose to.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	There was a lack of person centred care for people living at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The principles of the Mental Capacity Act were not being followed as assessments on capacity to make decisions were not completed in all cases where required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured that there were safe systems for the administration of people's medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider was not operating effective systems and processes to assess and monitor their service.

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 insufficient staff appropriately deployed to support people in a person centred and responsive manner.