Brooklyn House Limited

Brooklyn House Nursing Home

Inspection report

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Date of inspection visit:
04 July 2017
05 July 2017

Date of publication:
24 August 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

The inspection took place on 4 and 5 July 2017 and was unannounced. At the previous inspection of this home we rated it as Good in each domain. At this inspection we have rated it as Requires Improvement in each domain.

Brooklyn House Nursing Home is registered to provide residential and nursing care for up to 38 people. At the time of the inspection 38 people were living at the home. The home supports older people who have nursing needs, some of whom are living with dementia.

There was a registered manager in place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found four breaches of the Health and Social Care Act 2008. You can see what action we asked the provider to take at the end of this report.

Some risks to people's safety had not been managed well. The provider had not ensured that the number of staff they said they needed to keep people safe and to meet their needs, were consistently working in the home.

Staff had received training but not regular supervision. Staff practice was variable. Some staff were kind, caring and compassionate and treated people with dignity and respect. However, other staff demonstrated poor care practice. They did not always ask people for their consent before performing a task. Staff did not always interact with people in a meaningful way and restricted some people when they became upset and distressed.

The systems the provider had in place to monitor the quality and safety of the care provided were not all effective. They had not assessed some areas of risk to people's safety and had not ensured staff had been regularly checked to ensure they were competent at performing their role.

People received their medicines when they needed them and systems were in place to reduce the risk of people experiencing abuse. Any incidents or accidents that had taken place had been investigated and actions taken to reduce the risk of them re-occurring in the future.

People received enough food and drink to meet their needs. Staff supported them to maintain their health. Advice was sought from other healthcare professionals when needed and staff followed their guidance.

People had access to a variety of activities to provide them with stimulation. The staff encouraged visitors and relatives into the home. However, staff did not have much time to spend with people in their rooms to

reduce the risk of them becoming socially isolated.

People were supported with their cultural and diverse needs and their complaints and concerns were encouraged and listened to. Action was taken in response to people's feedback and they were involved in the development of the service.

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 consistently safe.

The provider had not made sure the number of staff working was in line with their own requirements.

Some risks to people's safety were managed well however, not all the risks which people faced had been assessed or effective actions taken to mitigate risks.

Systems were in place to protect people from the risk of abuse.

People received their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff were following the principles of the Mental Capacity Act 2005, when providing care to people who may not have been able to make a decision about their care.

People received enough food and drink to meet their needs and they received support to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff were kind, caring and treated people with dignity and respect and some people were supported to express their views about the care they received. However, this was not consistently applied across the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not all people's care needs and preferences were being met.

People had access to a variety of group activities but some people did not receive much social stimulation.

People's concerns and complaints were captured and listened to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Not all of the systems in place were effective at assessing and monitoring the quality of care people received.

People felt there was an open culture where they could air their views and they had confidence in the management. However, staff had mixed views in relation to this area.

People were involved in the development of the service.

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

This inspection took place on 4 and 5 July 2017 and was unannounced. The inspection team consisted of inspector, a specialist advisor who is a nurse by profession 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.

Before the inspection, the provider completed 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. The registered manager completed this and returned it when they needed to. We also reviewed the notifications the provider had sent us. By law, the provider has to send us certain notifications and we reviewed those we had received prior to the inspection. We contacted the local authority's quality assurance team and local clinical commissioning group to seek their views and we checked comments that people or their relatives had submitted to an 'on line' review service.

During the inspection we spoke with eleven people living in Brooklyn House and two relatives. Five of the people we spoke with were unable to give us a full account of the care they were receiving and therefore, we held brief conversations with them. Throughout our visit, we observed the care that people received.

We spoke with ten staff. This included care, nursing, kitchen, domestic and maintenance staff. We also spoke with the registered manager and the regional operations director who represented the provider.

We looked at various records in relation to six people's care. We also looked at three staff recruitment

records and information about staff training. Records regarding how the provider monitored the quality and safety of the care provided and the premises were reviewed.

Requires Improvement

Is the service safe?

Our findings

We visited the home in April 2015 and rated it as Good in Safe. However, at this inspection we have rated Safe as Requires Improvement.

Risks to the health and safety of people living in the home had not always been assessed. Reasonable actions had not always been taken to mitigate risks to people's safety.

Two people whose care we looked at had bed rails on their beds to reduce the risk of them falling out of bed and injuring themselves. For one person, a risk assessment regarding the safe use of the bed rails had been conducted six days prior to our inspection. It had been recorded on this risk assessment that the height of the bed rails was appropriate to reduce the risk of falls. However, we saw that the height of the rails was not sufficient to effectively reduce this risk. We brought this to the registered manager's attention and they agreed the bed rails were of insufficient height. They agreed to obtain the necessary equipment to correct this. There was no risk assessment in the other person's care record in relation to the use of bed rails. The registered manager told us one should have been conducted but could not locate it.

During our walk around the home, we found some prescribed creams within people's bathrooms or within their bedroom cabinets that were not secure. Some of these cabinets had keys in them so they could be secured but they were unlocked. Other items such as toiletries, steradant tablets and razors were also present. The staff told us there were people residing in the home who may not understand the correct use of these items. We therefore asked the registered manager whether they had assessed if any of these items posed a risk to people's safety. They told us they had not conducted such an assessment. The regional operations director told us they did not feel this was necessary as the items were out of sight.

In one person's room there were exposed pipes within their bathroom. The registered manager told us they had not assessed whether these pipes may cause a risk to someone if they fell against them. Although the person who resided in the room was not mobile, other people in the home were. The regional operations director said they would immediately arrange for these pipes to be covered. We also found a tin of fluid thickening agent in one person's room. This could be harmful if ingested. The regional operations director told us this should be kept securely and not in the person's room.

We found that various items of equipment had been left in the corridor during the day. We saw some people walking around the home who had reduced mobility and these items may have caused potential issues for people when walking around the home. Also, although the fire exits themselves were clear, these items could have been an issue should the building have needed to be evacuated. Downstairs in the morning, two wheelchairs and a hoist had been left out in a corridor. In the afternoon, one wheelchair and the hoist remained along with a chair used to weigh people. Upstairs in the afternoon, a crash mat had been propped up on its side in a corridor. We also found that one person's risk assessment in relation to their evacuation from the building in the event of emergency had incorrect information in relation to their mobility. This stated they were mobile with a frame but the staff told us they required a wheelchair and could no longer walk.

The provider had commissioned a risk assessment of the building in relation to fire safety from an external contractor in August 2014. There were no records to show that this assessment had been reviewed since this time. The regional operations director confirmed that an annual review should have taken place as a minimum. The registered manager told us they were not aware this should have been done. The provider could therefore not be assured that any potential new risks in relation to fire had been appropriately identified and therefore dealt with.

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

The provider had not ensured there were enough staff deployed to meet people's needs. We received mixed views from people about whether there were enough staff available to meet their needs. Four of the eight people we spoke with about this subject said there were enough staff. However, four people said either there were not enough staff or that this was variable at times. We also received mixed views from both of the relatives we spoke with. One person told us, "I need a lot of help but there is always enough staff to help me." Another person said, "Yes, there is enough staff for what I need." However, another person told us, "No, I don't think there is enough staff at busy times, such as evenings." Another person said, "Mostly there are but occasionally there's not."

We spoke with six staff about the staffing levels within the home. Two said that there were no issues with staffing levels but four said the levels were often variable. Some staff commented this was more of an issue in the early evenings. These staff told us they felt they could keep people safe but found it difficult to meet people's needs in a timely manner such as providing them with personal care. They also said they did not have time to speak with people unless they were performing a task such as helping them to wash and dress. These members of staff felt that some people received an inadequate level of stimulation due to staffing levels.

The registered manager told us they based the required staffing levels on people's care needs. They said this was reviewed monthly or sooner if a change in need was identified. They said the required staffing numbers had not changed since April 2017 and that these had been calculated as eight care staff and two nurses from the hours of 8am to 2pm and six care staff and two nurses from 2pm. Three care staff and one nurse were required to work at night. Due to the mixed feedback we had received from both people and staff, we looked at the staff rotas for the 26 days prior to our inspection, to see if the provider's requirements in relation to staffing levels were being consistently met.

We found that these levels had been met on all but one afternoon for nursing staff requirements. The registered manager informed us that they covered this shift. However in relation to care staff, these had not been met on 19 of the 26 days we checked. On one day, there had been only four staff working instead of six. The home was regularly working with one staff less for part of the day then they required. Also, five of the 26 nights had one care worker less than needed.

The registered manager told us they had experienced a high level of unplanned staff absence that they had found difficult to cover. They said when this happened they utilised existing, bank or agency staff. We saw that there was one bank nurse and one bank carer who were utilised to cover some gaps but no agency had been used in the last 26 days. We asked the registered manager why they had not used agency staff to cover staff shortfalls as this was part of their contingency. They told us that agency was not always reliable and were difficult to obtain at short notice.

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

The registered manager told us they had recently recruited a number of new staff and were continuing to recruit more staff that would help to cover unplanned staff absence.

Improvements are required to ensure checks of staff prior to their recruitment are robust. New staff had been subject to a number of checks. These included their identification, their conduct in previous employment and whether they had any criminal convictions or been barred from working within care. Nursing staff registration had been checked to ensure they were able to work as a nurse. However, the full employment history of two of the three staff had not been obtained as is required under the regulations. The registered manager agreed to ensure these were obtained in the future.

Systems were in place to protect people from the risk of abuse. All of the people we spoke with told us they felt safe living in the home. One person told us, "Yes, I just feel comfortable and safe." Another person said, "Oh yes, I feel safe here."

The staff we spoke with understood how to protect people from the risk of abuse. They were aware of the different types of abuse people could be subject to and said they would report any concerns to senior staff. Staff were also aware they could report issues outside of the home if they felt this was necessary and were aware of the provider's policy on whistleblowing. The registered manager was aware of their responsibility to report any alleged or actual abuse to the local authority. We saw this process had been followed, when this was needed.

The staff were aware they had to report any accidents or incidents that occurred. These had been documented and investigated by the registered manager. Action had then been taken to try to reduce the risk of the event happening in the future. For example, one person had fallen out of bed. They had not been injured but their bed had been replaced with one that was low to the floor and a crash mat was placed by the bed. This was to help reduce the risk of injury should they fall from their bed again.

People's risk of developing a pressure ulcer, choking, or the risk of not eating and drinking enough to meet their needs were managed well by staff. Staff knowledge in how to reduce these risks was good. In respect of pressure care, people had the necessary equipment in place and staff told us they regularly checked people's skin integrity. Any concerns found were raised with the nursing staff who took action to reduce any risk of a further breakdown in people's skin. We saw staff using good practice when helping people to eat and drink to prevent them from choking. This included sitting people in an upright position and making sure they received the appropriate consistency of food and drink. People were monitored closely to ensure they received enough food and drink to meet their needs. The nurses had regularly reviewed risks in relation to these areas to ensure people received the correct care.

People who could use their call bell had these within their reach so they could request staff assistance when needed. Records showed that those who could not use the call bell received regular welfare checks, during both the day and night.

Other checks in relation to fire safety had been conducted. These included checks of the emergency lighting, fire extinguishers and the fire alarm. The staff we spoke with told us they had received training in fire safety and the training records we saw confirmed this. The fire exits were clearly signposted to help staff in the evacuation of the building. Contingency arrangements were in place should the building become inhabitable for any reason.

Lifting equipment such as hoists had been regularly serviced in line with the relevant legislation to ensure they were safe to use. The gas system had been tested within the last year and the electrics within the last

five years to reduce any risks of malfunction.

People's medicines were managed safely. All of the people we spoke with said they received their medicines when they needed them. One person told us, "Medication is regularly on time and they always watch while I take them." A relative told us, "The staff bring the medication on time." Three of the four people said the staff did not ensure they had taken their medicine before leaving them. However during our observations, we saw good practice being followed by the nursing staff when they gave people their medicines.

The records we viewed in relation to medicines showed that people had received them when they needed them. These were kept securely for the safety of the people living in the home. Systems were in place to ensure people had sufficient quantities of medicines and these had regularly been reviewed by the person's GP to ensure they were appropriate for their needs. The temperature of the room where medicines were being stored had been regularly recorded. This was important to ensure the medicines were safe to use. The registered manager had identified that this temperature was regularly near the maximum recommended limit. In response to this, they had ordered an air-conditioning unit that was to arrive imminently.

The staff had received training in how to give medicines safely and their competency to do this had been assessed. People's allergies in respect of medicines were clearly noted on their records as was their preferred method for taking their medicines. Photographs were also present as an extra check for staff to help them ensure they were giving the medicine to the correct person. Protocols were in place to guide staff on how to give people medicines that had been prescribed on an 'as and when required' (PRN) basis. However, these were variable in detail. Some provided staff with good guidance as to when they needed to give the medicine but others did not. For example, where people had been prescribed a PRN sedative or anti-psychotic medication, the guidance for staff was to give them if the person became 'agitated'. There was no information about what strategies staff needed to employ first to support the person when they became distressed, before considering giving them their medication. We also found that one person's PRN protocol for a psychotropic drug had an incorrect maximum daily dose recorded on it. This was dangerously high. The person had not been administered the medicine at this dose and the risk was low that this could have happened. When this was pointed out to a nurse they stated it was a recording error and amended the form accordingly.

Body maps were being completed to show where a pain patch had been applied on the body. However, these were not being consistently used by all staff. This is important so staff can rotate the patches to avoid the risk of skin irritation. Staff were also not consistently recording the number of tablets they had given a person where the prescription was '1-2 tablets'. This is important so staff have a clear understanding of how many tablets a person has received to avoid them giving them another in error. We spoke with the registered manager about these areas who agreed to immediately review them and make the necessary improvements.

Requires Improvement

Is the service effective?

Our findings

We visited the home in April 2015 and rated the home as Good in Effective. However, at this inspection we have rated Effective as Requires Improvement.

Improvements are required to the support, supervision and training staff receive to ensure they consistently deliver effective care.

Some of the staff we spoke with told us they had not received regular supervisions to discuss issues such as their work or training. One staff member said they had never had any supervision meetings since they started working in the home over a year ago. However, after the inspection visit the registered manager said they had checked staff supervision records and told us the staff member had received a supervision within this timeframe. Another staff member could not recall when their last meeting had been held. Records showed this had been in January 2016. The staff also told us they were not having their care practice checked by senior staff to ensure they were competent to perform their role or had understood their training. The registered manager confirmed this was the case for both care staff and nursing staff, except for medicines the nurse's competency had been assessed. During the inspection although we observed some good practice such as staff assisting people to move safely, we also observed some poor practice in relation to offering choice, obtaining consent and consistently treating people with respect and dignity.

Staff had completed training that the provider had deemed as mandatory. This was in areas such as but not limited to, emergency first aid, fire safety, the Mental Capacity Act 2005, infection control and safeguarding adults. Most of this training was up to date. The registered manager had identified other training that staff needed to complete known as 'home-specific' training. This included subjects such as diabetes, end of life, pressure care and nutrition and hydration. Most of the care staff had not yet completed any of this training, although plans were in place for them to do so. However, none of the eight nursing staff had completed diabetes training and only one of them had completed end of life training and three, pressure care training. The three who had completed nutrition and hydration training were overdue this training. There were some people living in the home with diabetes and therefore it was important that the nursing staff had received training in how to support people with this condition.

Twenty-five of the 49 staff employed in the home had completed training in dementia care. This training called 'Living in My World' was an external workshop ran by City and Guilds. Some of the staff we spoke with who had attended this training told us it was very good and had improved their skills in relation to dementia care. This was important as over 60% of people living in the home were living with dementia. However, the registered manager told us that no staff had received training in how to support people with behaviour that might challenge others. The staff we spoke with confirmed this. It was evident through some conversations with staff and some practices they used, that they required further training in this area to meet the needs of people who regularly became upset or distressed.

The registered manager acknowledged they were behind with staff supervision and that some staff needed to complete further training. They had recently implemented a new system to improve staff training and this

was proving successful. Support was being provided by another registered manager with these issues. We also saw that most staff had a supervision meeting booked in the near future.

Improvements are required to ensure staff apply consistently the principles of the Mental Capacity Act 2005 (MCA) when providing care to people who may not be able to consent to it.

The registered manager told us that some people living in the home lacked capacity to consent to and make decisions about their own care. Therefore the staff had to comply with the Mental Capacity Act 2005. 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Of the three staff we spoke with about this subject, two of them had a good knowledge, but the other staff member had a variable knowledge of this subject. The staff told us they offered people choice and sought their consent. We saw that this sometimes occurred but was not consistently applied. For example, when administering medication the nurse sought consent from the person. However, during lunchtime we saw that staff did not always ask people for their consent when placing a clothes protector over their clothing. Some people were not asked where they wanted to sit in the dining room. One person was sat at a table but a nurse then asked a member of staff to move them to another table without consulting them. One person in a wheelchair arrived a little late into the dining room and there was no space at a table. Therefore, another person was moved from their place at the table to make room. They were positioned without being asked, in another part of the lounge area that was adjacent to the dining room. Staff had assumed these people were unable to consent to these decisions and so they did not check with them first. They also did not take any time to support these people to make these decisions.

The registered manager had assessed everyone in the home to see if they were depriving them of their liberty. They had submitted a DoLS application to the local authority for two of these people. They were awaiting the outcome from the local authority.

People's care records showed that their ability to consent to decisions had been assessed. However, this was not decision specific and was a blanket approach covering all decisions. These had also not been regularly reviewed to ensure they were current and correct.

The people we spoke with told us the food and drink on offer was sufficient for their needs. They said however, they were not offered a choice of food but that an alternative would be provided if necessary. One person told us, "The food is adequate but not many vegetables or fruit." Another person said, "There's no choice but they will always provide an alternative if I don't like the main course." A further person said, "Tea is usually sandwiches and when I asked if I could have a boiled egg they brought them loose on a plate with bread and butter. After I commented on it they went out and bought egg-cups." A relative told us, "The food is pretty good really. There's plenty to eat but it is usually sandwiches at tea time." They added that they found the dining room chaotic and crowded which meant their family member often struggled to keep focus when eating.

We observed the lunchtime meal. At times this was rather chaotic and not relaxing. The dining area was small with four tables, each with a seating for four people. There were no menus on the tables for people to

view. The registered manager told us this was because they were working on new menus. The staff assisted a number of people into the room in wheelchairs or specialist chairs and others made their own way to the tables at the same time. Due to the lack of space, we saw one person who was in a motorised wheelchair being regularly asked by the staff to move so they could assist people into the dining room. After the third time the person voiced some irritation. The lighting in the dining room was also low which may have made it difficult for some people with visual problems to see their food and drink.

Due to the small size of the dining room, not everyone could sit in this room to have their lunch if they wanted. One person was moved into the lounge to make way for another person who wanted to sit at a table. Some people remained within the lounge area whilst others had their meal within their rooms. Some conversation occurred between people and the staff during the meal however, at one point there were nine staff in the dining area moving around the tables which added to the lack of space and made the lunchtime experience less relaxing. We spoke with the registered manager and regional operations director about the size of the dining room. The registered manager told us they had recognised this was an issue and that plans were in place to extend the size of the dining room. The regional operations manager also suggested to the registered manager that the meal could be staggered over two sittings. The registered manager felt this was a good idea and said they would investigate this.

People were assisted with their drinks. Some were given a choice however, others were given a drink directly by the staff. One person said they did not want the drink offered and was given an alternative. People who may have found it difficult to make a decision about what food to eat where not always told what the meal was before it was served. One person told us they never knew what the meal was going to be but that they enjoyed the sweet option. These people were also not shown any different meals to help them choose if they found this difficult. The regional operations manager said this practice should be in place to support the person to make an informed choice. People who required assistance to eat their meals received this.

The staff demonstrated a good knowledge about people's eating and drinking needs and their likes and dislikes. They knew what specialist diets people required and talked about monitoring that people received enough to eat and drink. People had access to drinks throughout the inspection. We spoke with the chefs who were both working on the second day of our inspection. They told us that people did get a choice of two meals and they asked people earlier in the day what they would like to eat. They said that alternative meals would be made where needed. We asked the chefs whether people who may lack capacity got a choice of meals. They told us they were also asked but that those who could not make a decision would be given a meal they knew they were likely to enjoy.

The chefs were knowledgeable about people's dietary requirements. These were listed in the kitchen and covered areas such as diabetic, pureed or soft diets. Some people's food was being fortified with high calorie foods such as cream or butter where they needed support to put on weight. The chefs told us they had recently been on an external training course which had helped them understand how they could increase the calorific intake of certain food when necessary. This included making high calorie milkshakes which they said they had introduced and that some people enjoyed. Both of the chefs said this training had been very valuable in helping them understand how to improve people's nutritional intake.

People were supported with their healthcare needs. All of the people and relatives we spoke with agreed with this. One person told us, "A doctor is quickly arranged by the nurse if required." Another person said, "I made my own arrangements to see a dentist and I was taken by a carer." All of the staff told us they were able to support people with their healthcare. We saw that a staff member had been allocated to accompany a person to a hospital appointment on the day of our inspection. Records showed that where it was required, people saw their GP, dentist, optician or chiropodist. Other professionals such as dieticians and

speech and language therapists were also consulted as needed. We found that these professionals advice had been followed when required.

Requires Improvement

Is the service caring?

Our findings

We visited the home in April 2015 and rated the home as Good in Caring. However, at this inspection we have rated Caring as Requires Improvement.

Improvements are required to staff practice to ensure people are always treated with dignity and respect.

We received mixed feedback from people and relatives about the staff's approach to them. Of the six people we spoke with about this, four told us their experience was positive. One person told us, "The staff are kind, approachable and generally nice all round." Another person said, "The staff on the whole are very good, friendly and caring. I've no complaints about the carers or the nurses." However, another person told is, "The staff are okay but there are some I don't like much." Another said, "The staff are pretty good but I think a few need a bit more training." The two relatives also had mixed views. One was very happy with the staff reporting them as being 'patient, caring and cheerful' but another relative said, "There are some very good carers, some of the best I've ever met. But there are some not so good who could do with re-training."

During our observations, we saw variable caring practice amongst that staff. We saw one staff member sitting with a person whilst they ate their lunch. The staff member flicked through a magazine and monitored the person but did not speak to them. Another staff member assisted a person who was in bed to eat their lunch. They helped the person in an unhurried manner, but they made no attempt to talk to the person at all. We were aware from talking to this person earlier in the day, that they were able to engage in some level of conversation. However, we also saw some positive and caring interactions between the staff and people. One staff member was seen to get down to another person's eye level to provide them with comfort. Another staff member asked a person in their room if they were warm enough and whether they wanted a blanket. Staff were regularly complimenting some people who had had their hair styled earlier in the day by the hairdresser. The registered manager told us how they had on a particular weekend, bought their ice-cream trailer into work so that everyone could enjoy a whippy ice-cream. The registered manager told us that people very much enjoyed this experience. People's birthdays were celebrated where they received a meal of their choice and a cake.

All of the people we spoke with told us they felt the staff treated them with dignity and respect and that the staff knew them well. One person said when asked if treated with respect, "Oh yes, yes, yes but I do everything for myself." They added, "The staff know me as a person and I can talk in confidence to most of them." Another person told us, "The staff know me pretty well and I get on with them very well. They certainly treat me with respect."

Again we saw variable practice in relation to people being treated with dignity and respect. Some staff were observed knocking on people's doors before they entered into their room but this did not happen in all cases. Some staff always spoke to people respectfully, offered them choice and consulted them about decisions but other staff did not do this. Some staff referred to people as 'the softs' when talking about people who required soft or pureed diets which is disrespectful. The staff we spoke with repeatedly referred to some people as being agitated and this language was often reflected in people's care and medicine

records. When talking to one staff member about assisting a person with their bathing preferences, they told us this was dependent on the person's mood and whether they were in a 'thrashing mood'. The practice some staff followed in taking people back to bed or not getting them up in a timely manner in the morning due to their 'agitation' did not demonstrate a consistently caring approach by the service.

One staff member assisted a person to take a drink. We spoke with the person when the staff member had left and saw their face was unclean. The staff member had made no attempt to correct this for the person and so we had to ask a nurse to do it. Another person had been taken by a member of staff to bed in the afternoon. Their relative showed us that staff had placed the person in bed with a kink in their catheter. This meant it would not have been able to drain correctly, potentially causing the person to be in a wet bed thus compromising their dignity. Care and attention had not been taken to avoid this possible outcome when placing the person in bed. The relative told us they often found the person's catheter in this position and therefore checked it themselves each time they visited.

We also found that people's records were not always kept secure. Records in relation to one person's personal care checks were found outside their room. On the second day of our inspection, the door to the nurse's office was open. When we went inside the cabinet containing people's care records was open and one person's care record was open on a table. On the first day of our inspection, this cabinet had been kept locked.

All of the people we spoke with told us they did not feel involved in making decisions about their care but expressed to us they were happy not to be consulted about this process. We saw that when people moved into the home, they and/or their relative were asked what care they wanted and how this should be provided. Regular group meetings were held with people living in the home and relatives, where people could express their views about the service and the care they received. On the day of the inspection, such a meeting took place. We attended this meeting and people were given feedback on the latest satisfaction survey they had completed. Ideas and views were gained from people about how the quality of care they received could be improved. However, during the inspection we did not see that staff consistently supported all people to express their views and be actively involved in making decisions about their care and daily wishes.

The registered manager told us they had written to people and their relatives to encourage them to take part in the reviews of people's care. They told us this had worked well and that a number of people and relatives had taken part in this.

Requires Improvement

Is the service responsive?

Our findings

We visited the home in April 2015 and rated the home as Good in Effective. However, at this inspection we have rated Effective as Requires Improvement.

Not everyone received personalised care that met their individual needs. On the first day of our inspection, we found that at 10.30am there were four people on the first floor who were awake but still in their nightwear. We asked a staff member whether these people had received personal care. The staff member told us they had been checked and any necessary action taken earlier in the day, but they had not been washed or dressed. We asked the staff member why this was. They explained that one person was waiting for a relative who assisted with this but that the others were still waiting as they had not yet had time to get people up. We spoke with two of these people. One person told us they would like to get out of bed and expressed their surprise when we told them the time. Another person told us their preferred time to get up in the morning was 8.30am. When we checked their preferences in their care plan it stated their preferred time of rising was between 8.30am and 9am. Both of these people received assistance to get up after 11am.

We spoke with two of the four staff working on the first floor about this. They told us they had not had time to assist everyone in a timely manner. They also said they had been instructed by the nurses to support people who needed the help of one staff member first and then to attend to people who required two staff. This was not a person-centred approach. In these cases the needs of the staff and service were taking precedence over the needs of individuals. We spoke with the registered manager about this. They told us they were not aware that this practice was taking place.

Three of the staff told us there were some people living in the home who often became upset or distressed. They told us of various strategies they used to calm people when this happened. This included taking them to the sensory room or talking to them individually. One staff member said the sensory room was being refurbished so they could not currently use it. The registered manager said this was incorrect. We did see a staff member using distraction techniques with one person during the afternoon when they were in the communal lounge during a meeting. This had a positive and calming effect on them. However, the staff also told us that three people including this person, all of whom had been assessed as lacking capacity to make decisions about their care, were often either kept in their room until late morning or taken back to their room from a communal area in the afternoon due to their 'agitation'.

One staff member told us they did not get a person washed, dressed or out of bed until shortly before lunch because they upset other people living in the home when they were taken into the communal area as 'they get agitated'. We saw this person was in bed at 11am waiting for a wash. They were not distressed. Another staff member told us this was the same for another person living in the home. They also described how they would keep a different person in bed if they were 'agitated' or take them back to bed if they 'started throwing things' when in the communal lounge area. A further staff member told us how on the first day of our inspection, they had taken this person back to bed shortly after lunch as the person had started to 'reach out to grab people'. This person had only been assisted out of bed after 11am. On the second day of the inspection, we spoke with a senior member of staff about this person. They also told us that it was usual

practice to get this person up late in the morning due to their 'agitation'. They would then be taken down to the communal lounge for a short period of time and returned back to bed if they became distressed. This is poor practice and not based on these people's individual needs. We spoke to the registered manager about this. They told us they were aware staff were sometimes using this practice and said they had instructed them not to do it.

People's care needs and preferences had been assessed. Care plans had been developed once their needs had been identified. These covered various areas such as personal care, communication, mobility and eating and drinking. Preferences in respect of the times people liked to get up, go to bed, whether they wanted a male or female carer and their likes and dislikes in relation to food had also been assessed. It had been recorded that the nursing staff had regularly reviewed people's needs. However, the care records were large and difficult to navigate. We found some contradictory or incorrect information in relation to people's current needs that could be confusing for staff. Not all plans of care contained sufficient information to guide staff on how to meet the person's needs effectively.

For example, in one person's care plan in relation to their communication, it stated that the person could be disorientated and had poor communication. It did not say what techniques staff could use to support this person with their communication. It also stated that the person could not communicate their basic needs but then said they could choose what channel they wanted the television on. Regarding their needs in relation to food, one part of the care record said they were on a fork-mashable diet, another part said a soft diet and another part said a pureed diet. Their tissue viability care plan stated the person needed support to turn every three to four hours but in another part said every two hours.

For another person, they had a care plan in place in relation to seizures. There was no guidance for staff in relation to what signs and symptoms they needed to look out for and what they should do should the person be experience a seizure. Their mobility care plan said they could walk short distances with a frame but the staff told us the person was unable to do this. It was stated this person was diabetic but the registered manager told us they were not. There was also a lack of information in people's care records to guide staff on how to support them when they became upset or distressed. Triggers that may cause their distress had not been recorded or what techniques staff could use to help calm the person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

All of the people we spoke with told us that care was delivered to them that met their individual needs and preferences. They all said that they did not feel restricted in any way and that they chose their own times to get up and go to bed. They told us there was enough stimulation for them during the day and that they chose not to participate in the group activities that took place. One person told us, "I'm happy with my own company and I go and sit in the garden in nice weather." Another person said, "No, I don't want any more organised activities." One person told us how the staff had arranged for a priest to visit them each month in their room so they could take Holy Communion. They said this was very important to them.

Some people went to the local shop that was adjacent to the home to do their shopping. There was a small enclosed garden area that another person was seen using throughout the day to have a cigarette. One person was observed enjoying the sunshine in the garden at the front of the home. This garden was in the process of being developed into a sensory/memorial garden for people to enjoy.

The home employed an activities co-ordinator who worked five days a week. The registered manager had also arranged for an existing staff member to support people with activities over the weekend. This had been in response to people's feedback about activity provision. They were advertising for another member

of staff to work over these two days so that activities could be provided over seven days per week.

On the first day of our inspection, people were observed to enjoy a group activity of karaoke. This activity was fun and sociable. We saw a number of people engaged with this activity, they were joining in and smiling. People were given large flags and pom poms to wave. The activities co-ordinator was mindful to involve as many people as they could, giving them the opportunity to sing. Other people keenly watched what was going on. Some people had been given tactile items to touch and feel which provided them with sensory stimulation. These items gave them comfort. The registered manager showed us an apron they had made themselves for one person which had coloured items the person could touch and feel such as buttons. One person enjoyed holding a toy baby. The registered manager told us how they had bought the person a pram so they could take the baby for a walk around the home.

We spoke with the activities co-ordinator. They told us activities were planned with people each week and occurred in small groups. Activities such as exercises, karaoke, bingo, pet therapy and pamper sessions occurred. They said they tried to do music therapy and combine it with reminiscence as they found that a number of people enjoyed this and that it sparked conversation. People's life histories were captured where necessary which the activities co-ordinator told us, helped them and other staff to reminisce with people about the past. The home had access to a minibus and some people had been on excursions outside of the home to local areas of interest. One person had been taken to Duxford Air Museum due to their interest in aircraft. Another person had been taken to the cathedral due to their love of architecture. The activities co-ordinator told us they were involved in a project with a local school where school children would visit the people living in the home, which they said people enjoyed.

There was a sensory room in place that they said they used for people living with dementia to help calm them and provide them with sensory stimulation. They told us they encouraged people to join in with group activities if they wanted to and gave people a choice. We asked the activities co-ordinator if they were able to spend time with people who either chose to remain in their rooms or who were being cared for in bed. They told us they tried to visit these people each day and were able to spend around five to ten minutes with them. The records we saw confirmed this. However, we were concerned that some people in their rooms were at risk of social isolation. Although we saw staff checking these people regularly, asking them if they were well, they did not take the time to engage them in any meaningful activities or conversations. We fed this back to the registered manager. They told us they felt staff had time, but may have not been taking every opportunity, to speak with people.

The relatives we spoke with told us they were encouraged to visit often and all of the people we spoke with said they could see their relatives whenever they wanted. We observed some relatives visiting the home at lunchtime to assist their family member with their meal. The registered manager told us that Wi-Fi had been installed in the home so people could use the internet to stay in touch with loved ones.

People's concerns and complaints were captured, listened to and fully investigated. All of the people we spoke with told us they had not had cause to complain but would feel confident to raise an issue with the staff or registered manager if they felt it necessary. One person told us, "I would complain direct to the manager." Another person said, "I would raise it with a member of staff and I believe they would listen and act on it." A further person told us, "I would complain first to a carer and if that got nowhere I'd go to the manager."

The registered manager had set up a complaints book in the reception area of the home where people, relatives or staff could leave suggestions or raise concerns. The registered manager reviewed this weekly and wrote their response in the book so the person could stay anonymous if they wanted to. We saw that

the registered manager had considered each concern carefully and formulated a thorough response detailing what action they had taken. Action had been taken such as purchasing more fans for people in the warm weather. One written complaint had been received in the last 12 months. Records showed this had been fully investigated and a reply sent to the person who had made the complaint.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in April 2015 the service was rated as Good in all domains. However, the provider and the management of the home have not been able to sustain this rating of Good. We have rated Well Led as Requires Improvement.

Not all of the current systems in place to monitor the service were effective at identifying and improving the quality and safety of care provided. We found issues in a number of areas that had not been appropriately addressed.

Staff were completing daily checks of bed rails but they had failed to identify that one person's bed rails were too low to be effective at reducing the risk of them falling from their bed. When we spoke with staff about this, they told us they checked that the bed rails were working correctly and that they were covered. They were not checking for gaps or that they were of the appropriate height.

Risk assessments in relation to people's safety had not always been assessed and existing risks such as fire had not been reviewed in line with the provider's requirements. We saw that fire safety was an area the provider had checked during an audit they had conducted in June 17. However, they had not identified that the fire risk assessment had not been reviewed for over 34 months.

The provider had not ensured that the staffing requirements they said were needed to keep people safe and to meet their needs, had been consistently maintained. An audit of staff recruitment files had taken place but this had not identified that some new staff working at the service, had gaps in their employment. Recent audits of people's medicine records had not identified that some PRN protocols required more in-depth information for staff to follow before giving the person the medicine.

Issues were found with some staff practice. There was no system in place to monitor this area and staff supervision was not up to date. Leadership on the floor to ensure staff were working effectively was not always visible.

The provider had conducted an audit of the mealtime experience for people in June 2017 but had not noted any issues in relation to this. However, we found this to be chaotic with a lack of space for people to enjoy a relaxing meal.

When we looked at people's daily records in respect of personal care in an attempt to ascertain when this had been given. These did not give an accurate account of when this had been received. Staff gave us different accounts of when they needed to write in these daily records. One staff member said they wrote at the end of their shift the exact time personal care had been given, although when asked how they would remember the time, they could not answer. Another staff member said they sporadically updated a person's notes each day but that the time they recorded was when they were writing the entry, rather than when they had given the care. This meant that an accurate record of people's care was not always being kept.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Other systems in place to ensure people received appropriate nutrition and hydration and pressure care treatment were effective. Accident and incidents had been analysed each month for patterns and meetings held to discuss any falls people had experienced. Action had been taken where necessary to prevent the risk of people being injured through falls. Staff training was also monitored although some nursing staff had not completed training in key subjects. One staff member was not on the provider's training matrix that they used to monitor the completion of training. We brought this to the registered manager's attention who arranged to have the name added on.

All of the people we spoke with told us they were happy living in the home. One person said, "Yes, I must say that I am happy living here." Another person told us, "I would say that I am content rather than happy." The relative was also happy with the level of care being provided to their family member.

Everyone knew who the registered manager was and said they saw them around the home. They said they felt confident to raise any concerns and approach the registered manager and were confident their concerns would be listened to. A relative told us how their opinions and thoughts were always respected by the nursing staff and management in the home.

We received mixed views from staff regarding the culture in the home and the support they received. Two of the four staff we spoke with about this told us the culture was open and they could raise concerns which would be dealt with and listened to. They described their personal morale as high and of feeling valued with an approachable management team and good teamwork being in place. The two other staff told us the complete opposite saying their morale was poor, there was a culture of bullying in the home and that there was discourse between the care and nursing staff. We spoke with the registered manager about these varying views. They told us they were aware there were some issues between some staff members and they were actively working on this with the support of the provider. They also said they had arranged some team building days and activities in an attempt to improve some staff's morale and feeling of inclusion. The provider had set up a confidential employee assistance programme that was available to staff 24 hours a day. This offered practical and emotional support services that included stress management, team building and conflict resolution.

During the inspection, we found that leadership was not always evident or observed within the home to guide staff and ensure they followed good practice. One person sitting in a communal area was seen to be approached and provided with a drink by three different staff in quick succession whilst other people were not engaged with. There was a lack of visible presence of nursing staff directing and offering staff support. We did not see a nurse overseeing the welfare of residents in their rooms upstairs during lunchtime. The registered manager told us they had discussed with staff in a team meeting that it was not always appropriate to keep people in their rooms until lunchtime or take them out of communal areas just because they became upset but staff were still doing this. This poor practice had therefore not been monitored effectively.

People were involved in the development of the service and in improving the quality of care they received. Questionnaires had been sent to people and their relatives for feedback. The registered manager had put in place an action plan in response to any comments. We saw that action had been taken. For example, some people and relatives had expressed a wish for more fresh fruit and vegetables to be offered. In response, the registered manager had recently arranged with a local fresh fruit provider to obtain their produce on a regular basis. People who requested various trips had had these arranged and more activities at weekends were being put in place. Relatives had asked for more coloured tactile cushions and these were being

purchased.

The registered manager was also in the process of simplifying the communication of people's needs to staff. This was in the form of a laminated document that held some key information such as any allergies the person had, their mobility, diet and preferences. This laminate was able to be hung up in the person's room and to protect their privacy, the other side was a picture.

Team meetings had been held to discuss and communicate issues to staff such as infection control, health and safety and people's needs were taking place.

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	The care and treatment received was not always appropriate. Care had not been designed with a view to achieving service user's preferences and ensuring their needs were met. 9 (1), (3) (b) and (c).

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	Risks to service users' safety had not always been assessed and reasonable actions not always taken to mitigate risks. 12, (1), (2) (a) and (b).

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	Not all of the systems in place were effective at monitoring and improving the safety and quality of care provided. Records had not all been maintained securely and an accurate, complete and contemporaneous record in respect of each service user or person employed was not in place. 17 (1) and (2) (a) (b) (c) (d) (i) (ii) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
	There were not always enough staff deployed

Treatment of disease, disorder or injury	to meet service user's needs. Regulation 18 (1).