Four Seasons Homes No.4 Limited

North Court Care Home

Inspection report

108 Northgate Street
Bury St Edmunds
Suffolk
IP33 1HS

Tel: 01284763621
Website: www.fshc.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We last inspected this service on the 11 and 16 November 2015 and found the service was failing to meet the required standards. At the time of this inspection in November 2015 there was a registered manager in post.

The inspection in November 2015 was planned as a responsive inspection because of concerns received about the safety and well- being of people using the service.. During our November inspection we found wide spread failings and breaches of a number of the regulations.

We rated the service as inadequate and put the service in special measures which meant the service was given a specific period of time to improve We also took enforcement action to ensure to restrict further admissions to the service until such a time we had judged them to be providing safe care.

Following the inspection in November 2015 we met with the Regional manager and Registered manager to discuss our concerns. We have also communicated our concerns with the Local Authority so they could continue to support the service to improve. Following this inspection in November, the service sent their action plans stating what they had already done and what they were going to do to improve the service. They told us when they expected to have addressed all of the concerns identified.

We carried out this inspection on 13 April 2016. At the time of our inspection the Registered Manager was no longer working at the service. The provider had acted swiftly to appoint a new manager who came into post in February 2016. The provider also appointed a deputy manager and had a member of staff working as clinical lead in an administrative role. This new team are starting to establish good practices within the service but it is too early to judge the effectiveness of this. The manager has put in an application to be registered with the Care Quality Commission which will be processed in line with expectations.

At this inspection in April 2016 we found that staff knew how to raise concerns and protect people as far as possible from avoidable harm or poor care and treatment. A number of staff had raised concerns previously but felt their concerns had not been listened too but were more confident in the current management and response from the organisation.

Risks to people's health and safety were not always clearly documented and we found variable practice within the home. We identified hazards to people's safety and in particular poor monitoring and poor infection control. We also identified improvements were required in the way people received their medicines. Records relating to this required improvement.

Staffing levels had improved and the considerable staff vacancies reduced. We were not fully confident about the skills mix and competencies of all the staff due to poor past supervision and monitoring of staffs practice and lack of clarity around roles and responsibilities. Staff shortages also occurred occasionally. The impact of this was that people did not always receive the care according to their expressed wishes.

Staff felt well supported through induction, training and monitoring of their performance which will take a while to embed.

Support people received at lunch time varied and people did not always receive adequate monitoring of what they were eating and drinking and if it was appropriate to their needs. Some of this was due to poor record keeping and not all staff being fully aware of people's needs.

Peoples health care needs were not always adequately monitored so staff could respond appropriately for reasons cited above.

The service supported people appropriately and worked in accordance with the legal requirements in terms of their capacity. Staff did not always provide information in a way which enabled people to make an appropriate choice.

The staff were caring and care practices had improved with people receiving care which was more responsive to their individual needs.

Consultation with people using the service was improving and people's preferences of care were taken into consideration along- side their feedback about the quality of care and overall satisfaction.

Although staff were more responsive to needs care plans did not always give us enough information about people's needs or how staff should meet them. The level of activity for some people were not adequate. This meant that for some people there was little evidence of them participating in any activity which they might have done if sufficiently supported to by staff.

The service had an established complaints procedure and people had growing confidence in raising concerns.

Improvements have been made in the overall quality and experiences for people using the service. There was better engagement with the voluntary sector, improvements in staffing levels, activities of daily living and the environment. However we still have concerns about the quality of the nursing care provided and found records not up to date or reflecting people's current needs or risks. We were not confident with the staffing mix and whether all staff were sufficiently competent to fully meet the needs of the people they cared for.

We have also been concerned that a number of incidents/concerns either have not been reported to us or documents have not been forwarded to us in a timely way when requested. This has resulted in a loss of confidence in the service and their processes in terms of openness and transparency.

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

Risks to people's health and safety were not always adequately documented or acted upon.

People generally received their medicines safely but some improvements were identified.

There were generally sufficient staff but we were not confident all staff had the necessary skills and competencies.

Staff recruitment processes were adequate.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported to eat and drink enough or have a diet suitable to their needs. Food and fluid monitoring needs to be consistent across the service.

People's health care needs are not always met due to a lack of staff knowledge and poor record keeping.

Staff skills and knowledge needs to be improved through additional monitoring and observation of staffs practice. Training around specific needs also needs to improve.

Staff had a good understanding of how to support people with decision making and when to act in a person's best interest.

Is the service caring?

Good

The service was caring.

People were supported by caring staff who had been supported to provide dignified care. However previous concerns about care practices had not been identified or acted upon swiftly and this had resulted in a number of people continuing to receive poor care following the last inspection.

People were being consulted and care provided was centred more around their individual needs. Engagement of volunteers had helped

Is the service responsive?

Requires Improvement

The service was not always responsive

Social activities had improved but we could not see how everyone was supported around their individual needs or how staff supported people remain connected with their past.

Care plans require further improvement so they reflect the current needs of people using the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management of the service was improving and the new team were in a good place to bring about the required improvement.

Communication had improved and the service was engaging with the community to improve the experiences of the people using the service and to enable people to go out into the community. Family support was really good and there was a growing confidence in the service.

There were systems in place to review the quality and effectiveness of the service but concerns we had identified at previous inspections and this inspection had not been identified or addressed by the service so we could not be assured of the effectiveness of the service monitoring.

North Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 13 April 2016 and was unannounced. The inspection was undertaken by two inspectors, one of whom was specially deployed to speak with relatives, visitors and people using the service. There was also a pharmacy inspector and a specialist advisor who was a qualified nurse with many years' experience in care and management.

Before the inspection we had met with the previously registered manager and regional manager and also the Local Authority and safeguarding team to share concerns and see what was being done to support the service. We looked at previous notifications which are important events the service is required to tell us about. We also received information of concern from Whistle-blowers and relatives which we explored further. On the day of our inspection we observed the care being provided on the ground and first floor, we spoke with nine staff, twelve people using the service and seven relatives. We looked at seven care plans, and tracked the care of three people whose plans we looked at. We completed a detailed medication audit on both floors and looked at records pertaining to the management of the business and some staffing records.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in November 2015 we found there were not always enough staff with the right skills to meet people's assessed needs in a timely way. Since this inspection the number of people using the service had dropped significantly since actions taken by CQC to prevent further admissions. We were satisfied at this inspection that staffing levels were being maintained to ensure there were enough staff to meet people's defined needs. The service had a way of assessing people's levels of dependency and using this to calculate how many staff they needed. However individual dependency assessments were not updated in the records we looked at. The service had a total of 38 people using the service, 14 on the nursing floor and 24 people on the dementia unit. The service is registered to provide care for up to 57 people.

Staffing levels did vary, on the ground floor which was mainly for people with dementia. There were two units; one unit only had one member of staff working which was difficult as some people needed assistance by two members of staff so the staff had to wait until someone was free. We noted that breakfast, (porridge) was served and went cold for one person and staff did not offer to heat it up. We asked people about staffing on the unit with only one staff member on. One person told us, "Staff are fine, not really enough of them. They are up and down the corridor." Staff spoken with generally felt there were enough staff and said things had improved with a significant reduction in the number of agency staff who had been replaced by permanent staff. Relatives spoken with said there were not always enough staff citing the weekends as problematic. Another said supervision of people was not always appropriate due to staffing levels.

At the last inspection we identified a breach in Regulation 18, staffing. At this inspection in April 2016 there were enough staff on the day of the inspection. However we were concerned about the skills and experience of the staff. The floors were being run by an agency nurse on the ground floor who had been to the service regularly in the last few months but only on several days a week. The deputy manager was at the service and supporting the agency member of staff. On the first floor which is a nursing unit there was a care home assistant practioner, (CHAPS) who was a member of care staff without nursing qualifications. They had a qualification in care and had received additional training to enable them to undertake tasks which might have previously been carried out by a nurse, such as taking blood, and administering medication. However there was not enough evidence of their clinical skills to lead the floor or how their practice and competencies had been assessed in the workplace. This was the same for other senior staff leading shifts some of whom were not familiar with the needs of the people where they had been designated to work. The organisation was investing in CHAPs partly as a response to the issue of nurse recruitment. The service had significant nursing vacancies. The acting manager told us a clinical lead would be appointed permanently for each floor when they were fully occupied. There was a deputy manager (a registered nurse), and acting manager but both were new to their role and it was not clear that their roles and responsibilities were clearly defined. There were not regular observations of staff practice or close monitoring of staffs practice to ensure their training and induction had given them the skills they needed. This was a continued breach of Regulation 18 HSCA 2008 (Regulated Activities)
Regulations 2010 Staffing.

Medicine practices were observed and we looked at the underpinning documentation to ensure medicines

were given as prescribed and by staff who were sufficiently trained to administer medicines. We saw in people's care plans a description of medicines people were taking, what for and common side effects. There were protocols and pain assessments in place for people but we saw that people were not always given pain relief as required. One person sometimes required pain relief before a dressing was changed but had not been given it when their pain score was high but had been given it when the pain score was low.

We saw a number of tubes/pots of cream which had no opening date on them but an expiry date. Some of these expiry dates had already passed. Staff responsible for administering medications told us they would expect staff to tell them when creams were out of date but we also said we would expect there to be regular checks to ensure creams were in date. Creams out of date with no opening date recorded means there is an increased risk of bacteria growing in them and them becoming less effective. Where creams are in tubs and fingers have to be used to obtain the cream, there is a greater risk of cross infection, especially if it is not discarded after one month. Large dispensers of cream are normally suitable for three months, if not used before.

Our pharmacist inspector looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.
People living in the service were not always receiving their medicines as prescribed. When we compared medicine records against quantities of medicines available for administration we found numerical discrepancies that showed that medicines had not been given as intended by prescribers. The service had put in place a recording system to account for medicines but this was not being kept up to date or completed accurately.

There was supporting information to enable staff handling and administering people's medicines to do so safely and consistently. For people prescribed painkilling medicines and who were unable to talk about their pain there were pain assessment tools to enable staff to give them their painkillers consistently. There were additional charts to record the application and removal of skin patches. However, there was a lack of written information on people's preferences about having their medicines given to them. There were people with limited mental capacity to make decisions about their own care or treatment who had their medicines administered to them crushed in food (covertly) without their knowing. There were records showing staff had made best interest decisions on their behalf and consultation with their GP and relatives about this. However, there was no written guidance for staff to refer to about administering their medicines or records about consultation with the pharmacist to ensure their medicines could be given to them in this way. We noted that when people were prescribed medicines on a when required basis, there was not always written information available to show staff how and when to administer these medicines. Therefore people may not have had these medicines administered consistently and appropriately.
Oral medicines were stored safely for the protection of people who used the service and those requiring refrigeration had been stored at correct temperatures. However, in one area of the service the arrangements for the storage of controlled drugs did not meet relevant controlled drug legislation (controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse). We found that some medicines prescribed for external application located in people's rooms were out of date and so were no longer safe for use.

The manager showed us records confirming that staff authorised to handle and administer people's medicines had received training on medicine management and arrangements had been made for staff to undertake further training, however, they had not all recently been assessed as competent to undertake medicine-related tasks.

In respect to medication we identified two breaches- They were in regulation 12 Safe care and treatment

and regulation 17. Clinical governance.

At the last inspection in November 2015. We could not see clearly how risks to people's health and safety were being effectively managed. At this inspection in April 2016, we identified a continued breach with this regulation as we found some records were up to date and others were not. Records were ambiguous and we could not always see if risks were fully mitigated. Risk assessments were not always in place. For example for the people we case tracked where bedrails were required there was no evidence in their records of visual checks being carried out. There was no risk assessment for the use of bedrails or reasons for them to be in place or if bumpers, (padding) were required to protect the person from injury. Information about some people's needs in relation to eating and drinking was contradictory with different pieces of information- ie normal diet, purred diet. This led to a person being given food which was not appropriate and they chocked on the food which staff were quick to intervene. However on further exploration the person's needs had changed but not all staff were aware of this and their records did not contain only relevant information. The person did have an updated risk assessment for the risk of aspiration but this had not been followed.

The information about people's skin integrity was variable. We saw that for some people where they had sustained injury's this had been recorded but we could not see how it was followed up and there were discrepancy in the dates we looked at. One person's plan said their skin was intact but there was subsequent recording of bruising. One record/body map said a datex had been recorded which was a record held by the manager and which could be viewed by the Regional /senior management team to see if actions taken were appropriate. However in the person's individual records there was no information in their care plan or daily notes to indicate how bruises/marks might have occurred, who found it, if it was reported, or if any investigation had taken place. We observed two incidents during our inspection which were responded to quickly. However on leaving we checked records and neither incident had been written up at the time.

The room documentation had been copied from the persons care plan and was difficult to read. There was written information concerning bed rails and what to look for, none of the records made mention that the bedrails had been checked. The booklet for Position Change/ bed/ chair was a record of position changes, but did not record the person's skin condition.

Where required people had pressure relieving mattresses. However the care plans did not state when this equipment was in place or what setting they should be on. Another person had a pressure sore and was on a pressure relieving mattress but neither the setting nor their weight was recorded in the care plan. This is poor practice as any equipment being used should be recorded in the care plan and the setting required to give the most effective pressure relief should also be recorded, so that regular checks can be made and recorded.

In one person's records we found only one entry of them having a bowel motion and then nothing for a further ten days. There was evidence that a senior had on more than one occasion signed this form to say they had checked it but not what actions they had taken. This indicated that the carer was reviewing the records without being aware of what they were reviewing and the importance of the monitoring in relation to the persons health and the serious implications of constipation in an older person. We saw for another person a period of eight days had lapsed between bowel entries and checking their medication record showed they had not been administered anything to help with constipation.

We looked at wound care documentation and saw this was not robust or that each wound was described. A person with a pressure ulcer had a photograph of the wound but this did not include any measurements of the depth, size of the ulcer. We found it difficult to assess how the persons wound care was being managed

as there was an initial wound care assessment with a date of review but no other information but then additional information of when it was redressed was included in the daily notes, and or the room documentation and not in the wound care plan. It was therefore difficult to find when the wound care was last given. We saw another example of a person who required their leg to be redressed in two or three days- from the 08/04/2016 but when we checked with staff this had not been recorded as done and staff confirmed it had not been done.

This was a continued breach of Regulation 12. Safe care and treatment.

At the last inspection in November, we identified a breach in regulation 15.At this inspection in April 2015, we identified continued concern around infection control. We observed staff as they assisted a person with personal care. They wore gloves and aprons and observed basic hygiene principles. However later on that morning just before lunch we went back to the persons room and found two empty drinks beakers and water jug were still on the bed table. The en-suite toilet contained a dirty, stained and unused small bowl. A pot of Sudocream and toiletries. There was a rubbish bin in the room; it had no liner in it. The nasal cannulae for the oxygen, was lying on the floor with the tubing, the nasal section was soiled with dried nasal secretions. We went to the dining room at 16.00 hours and found that some dirty plates, cutlery and glasses were still on the side of the sink area. The floor was sticky and had spilt food on it. This is poor practice to leave soiled plates and empty beakers in rooms, as they will encourage bacteria growth. It also shows poor management of staff and the basic cleaning and tidying tasks they need to do to maintain a clean working environment.

We observed the domestics at work and asked them if they collected cups. They said no carers do that. We observed domestic staff cleaning the door handles of the room and the en-suite. The service appeared clean with no odours and obvious hazards. We found a number of rooms such as the sluice which should be locked for people's safety open. Staff locker rooms were also open and toiletries and razors on top of lockers. There were also a number of tools left out. There had been an incident that morning in which a person had become distressed we were concerned that hazards could increase the risks to people's safety.

There was a continued breach of Regulation 15. Premises and equipment.

Monitoring for people's safety was managed through regular observation. One relative had raised concern about the communal area left unattended but felt since they raised concerns this had not happened again. We viewed care plans and it was difficult to see the rational as to how often people should be checked for their safety. For example one person at high risk of falls who spent lots of time in their room and who had been assessed as unable to use the call bell was to be checked four hourly during the day and two hourly checks at night which did not seem proportionate to the risk.

Staff spoken with had received training in protecting people and knew how to respond to allegations of abuse and poor practice. Staff were reminded of their responsibilities during supervision. They had access to policies and training to help reinforce their duty to act upon concerns. Some staff had told us that reported concerns had gone un-noted but were more confident in the current management team. The Safeguarding team had been instrumental in investigating a number of concerns and poor practice had been identified at our previous inspection. The service had not yet demonstrated how they were being proactive in ensuring all staff provided appropriate care to people to the highest standard.

Staff recruitment processes were acceptable and tried to ensure that only suitable staff were employed at the service by checking their qualification's, previous work history and by taking up references. Staff underwent an interview to help establish if they had the right skills and attitudes and then were supported

through a nationally recognised induction. Checks were completed to ensure staff were permitted to work in the UK and had not committed an offence which might make them unsuitable to work with older people.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in November 2015, we identified people were not always having their needs met and identified a breach in relation to regulation 12 safe care and treatment. At this inspection we were not confident that people's health care needs were being adequately met. This was because there was poor evaluation of risk and care plans were not in place for every aspect of health care to alert staff as to what to look out for or what actions they should take. For example we saw one person was prone to regular urinary tract infections which had required antibiotics. However we were unable to find any information concerning any interventions or plans to manage this. There was no specific guidance for staff on the effective use of oxygen for people who required it. There was nothing about breathlessness or its management.

People's continence was not well managed. We saw a number of records which described people as continent and incontinent, both were supported by staff by using incontinence pads day and night. There was nothing place to try and promote people's continence where they were able to communicate their wishes and still if encouraged be able to use the toilet. The continence section of the care plans gave no details of the type or size of incontinence pad to be used. Each person has to be assessed and should then have the correct pad used, if the incorrect size or absorbency is used it could mean that the person has problems with excess leakage and then skin integrity could be compromised, due to the effects of urine or faeces on the skin. We identified another person who appeared to be running a high temperature; staff attempted to cool them down but did not take their temperature as we suggested.

This was a continued breach of Regulation 12, Safe care and treatment.

At the last inspection in November 2015 we identified a breach in Regulation 18 as there were not enough staff or staff with the necessary skills and experience to meet people needs. At this inspection in April 2016 there was some improvement however we still had concerns about the staffing skill mix on duty. We looked at staff training to see if they had the skills and competencies to meet the needs of people using the service. The organisation was investing in CHAPS which was offered to care staff and gave them opportunities to achieve additional qualifications and undertake enhanced duties traditionally undertaken by qualified nurses. At North Court they only had one member of staff in this role and we saw they had completed enhanced qualifications in care but their competencies had not been assessed in the work place. They had done additional training in medication administration, wound care and PEG feeding. They had also completed a 3 day First Aid. The organisation were investing in senior staff and giving them opportunity to partake in management training to enable them to take on additional responsibilities for managing staff.

During our inspection there was only one permanent trained nurse on duty and the only nurse who could undertake some nursing duties, They were supported by an agency nurse. for example male re-catheterisation. They said they were in the process of trying to get training for other Registered Nurses. Currently there were no nurses who were trained to set up a syringe driver if a person required it. They said they had been in contact with the Hospice to try and arrange training for the Registered Nurses with syringe drivers and End of Life care. All staff training was provided in dignity in care.

We spoke with care staff. They told us they had completed all their mandatory training mostly through e-learning. Some additional training was being planned including more enhanced training for staff about the experiences of people living with dementia. Some staff had completed more specific training around people's needs such as diabetic care, mental health, end of care and person centred planning. Staff felt the training was enough for their role and things had improved with daily meetings being held which were inclusive of all staff and gave them opportunity to flag up any concerns about people's care and welfare. We viewed the training matrix and saw that most training was up to date. However where it had lapsed staff had been sent a reminder letter and given two weeks to complete.

The acting manager told us that new staff were supported through induction and were supported by a more experienced member of staff. We did not look at documentation but saw the initial two day induction and staff said they had been observed with some key areas of practice such as giving personal care and manual handling. The acting manager said they were identifying care coaches and have rolled out the new care certificate which was a recognised induction for care staff which covered all the key competencies and skills required.

We had concerns that only one member of staff held a train the trainer course in manual handling and this was not sufficient to support all staff with the manual handling training and observations of their practice.

We identified a continued breach with regulation 18 –Staffing.

At the last inspection in November 2015, we identified a continued breach in Regulation 14 meeting people's nutritional and hydration needs. At this inspection in April 2016 there was some improvement. We observed the lunch time period on both units and saw that it was a mixed experience for people. Relatives told us the quality and presentation of the food was also variable depending on who was cooking. One person described the food as, "Beautiful." We observed that the meals were well presented. People told us they had enough to drink and staff gave them a choice. Staff told us the food had improved particularly in terms of choice. On the ground floor there were both, relatives, staff and a volunteer helping which meant people were served and assisted with their meal in an appropriate way. Food looked appetising and served hot. Some flexibility was offered in the choice of food. However choices were not offered to people in a meaningful way. Staff did not use different plate options to help people decide what they wanted or pictorial menus so we were not assured people had a meal of their choice. Some people were encouraged to the table, others were not, and some people had already finished eating as others were just coming to the table. One person who had been asleep throughout the morning was woken up for their dinner. They were not initially supported with his food and was observed trying to eat off the floor. Staff did then encourage them to eat and they ate all of their meal all be it with his knife. We noted on the ground floor food was plated up in the kitchen and then brought out which meant people were denied any real choice or benefit of the smells, sight of food.

On the nursing floor the experience was not personalised for a number of people. Only a few people ate in the dining room. An incident occurred with one person being given food they were unable to manage. Staff supporting them were not aware of their specific dietary requirement. We checked in their care record and with the kitchen staff and there was different information recorded about their dietary needs. This lead to unsafe practices. One person was given apple juice but when we looked in the care plan their record said they did not like apple juice. The carer was not aware of this. Choice was offered but only through our observation when it was clear people were not eating what they had been given. One person asked for a small pudding and was given a large bowl in which they only ate half of it. We observed staff supporting people in their rooms and saw that staff were generally familiar with people's needs and where people had

not eaten they tried again later. However we also observed food going cold because people were not eating and staff did not offer to heat it up.

We noted for one person with poor nutrition and poor skin integrity snacks were not offered between meals. Our expert identified this as poor practice because the person had a pressure ulcer and required additional nutrition to heal. Their weight record also showed gaps so we were not assured they were being weighted weekly as required. The person had lost weight over a period of time and there was poor monitoring of this. Staff told us they weighed people at the weekend but there were no staff specifically responsible for overseeing people's weights. We could not always see how staff acted promptly when a person had unintentionally lost weight. We saw for some people they were gaining weight and some people had been referred to the GP and dietician for dietary advice. However we did not see a consistent approach to weight management. For Example one person's records showed us they had steadily lost weight over a period of time. In February 2016 a referral had been made to the dietician and advice had been given about helping them maintain their weight. However they were continuing to lose weight so we could not see if interventions were working or actually happening. They were meant to be regularly weighed but this was not happening as it should and weights recorded in both people's care plans and held in the office showed gaps. Staff were unable to tell us who should be weighted weekly. Nutritional assessment had not been updated for two months in some cases so we were unable to assess if the actions taken by staff were appropriate to need or reduce the risk of malnutrition.

We identified a continued breach of regulation 14: Meeting nutritional and hydration needs. .

We had reports of poor staff practice which were identified as part of our last inspection and we have received subsequent concerns. We were unable to establish how effective supervision had been in the past because records were poor. However staff supervision was taking place and had improved in terms of the content. The acting manager told us they were starting to carry out direct observations of practice but we were concerned this should already be established given the concerns that had been raised. Staff had received group supervision and been given information about our inspection processes and what we measure a service against in order to decide service ratings.

Care plans included information about people's ability to give consent about their care and treatment and their preferences. In some instances it was considered that people were unable to retain information and unable to consent. Their capacity had been assessed and decisions about their care and welfare was clearly documented showing who had been involved in making decision about a person's care and welfare and the rationale for this showing how a decision was made in the persons best interest. Capacity assessments were kept under review. Where people had been deemed as lacking capacity a Deprivation of Liberty safeguard (DoLs) application had been made to the Local Authority but to date only one had been authorised. The provider must also notify CQC of any DoLs applications when authorised. Staff had received training and had sufficient knowledge of legislation.

We spoke with people about their health care needs. One person told us they could see the doctor when they wished and recently staff had arranged for them to see the optician.

Good

Is the service caring?

Our findings

At the last inspection in November 2015 we found a breach in regulation 10 Dignity and respect as we had observed some uncaring practice. At this inspection in April 2016 we observed caring practice and staff were familiar with people's needs and we saw genuine signs of affection. One relative told us staff regularly comforted and hugged their family member if distressed. We observed staff talking to people in a friendly manner; they gave them eye contact and gave them time to answer.

We spoke with visitors and relatives most of whom were complimentary about the care being provided at the service. For some relatives they reported an improving picture, for others they felt they had never had any concerns about the care provided. One relative told us staff are, "really good. " They said it did not matter what time of day they came in they always found the same and did not have any concerns.

We observed staff acknowledging people and taking time to find out what they wanted and acting in an inclusive way. One member of staff was writing care plans but they spoke to people using the service as they did so. We observed a carer helping a person with their lunch. They maintained eye contact and spoke with the person smiling and encouraging them to eat and drink.

We observed people's personal appearance and saw that people were well groomed and people told us they regularly saw the hairdresser and also had their nails done. Staff were kind with people and supported them with their needs. People were offered a choice about what they wished to wear and staff chatted to people about their appearance. Some people in their room had music or the television on and staff popped in. We noted one person had ill-fitting trousers on which fell down on several occasions which was undignified and they were not supported to change them.

The service environment had been vastly improved and we saw people sat in communal areas were comfortable and had magazines including the daily sparkle which was a magazine about (past times) People were being offered baths and there were some activity. We spoke with a relative who told us, "We are impressed; my relative is well cared for. They enjoy a bubble bath. They are always clean and their room has a new carpet and painted walls." They told us staff get them up and they chat with other people. The relative said they had become, "Interested in life again."

Another relative told us the regular staff were very caring and said their family member is now receiving regular baths and felt the arrangements for the laundry were fantastic.

There was some evidence that people were consulted about their plan of care and families were kept up to date with the care needs of their family member. Resident's and relatives meetings were scheduled but the frequency/attendance of these in the past had been poor. Information around the service told people and their relatives what was going on and there was a regular newsletter available for all to read.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2015 we found, the service was not responsive and there was a breach of regulation 9 person centred care. At this inspection in April 2016 relatives were positive about the care provided and through our observations we could see people were generally in a positive state of well- being. Comments from relatives included, "They are putting on weight." "There is a better atmosphere in the home." "My relative liked the visiting zoo, they are always well presented and seems a lot less anxious since they have been living here. "

We carried out observations throughout the day to see if the care being provided was effective and responsive to people's needs. We noted on the ground floor there were two units and one unit was not staffed adequately which meant people had to wait for their care as the staff member needed to wait for assistance from other staff members. This meant care was not always responsive to people's individual needs. However in the other unit the care we observed was mainly positive. People were well dressed and their personal appearance was attended to. . A number of people had been supported to have baths and people were encouraged to get up when they wished and when appropriate come in to the communal areas. There were a number of activities taking place by a person employed to provide activities. These were not as well managed as they could be because the activities coordinator was often the only staff member in the communal area so often had to stop what they were doing to reassure or support other people. One lady was having her nails manicured and the staff member had to stop several times. In the mean- time the person fell asleep. The activity coordinator shared their time between floors which meant in the morning there were no planned activities on the first floor although at least one person came down to the activities. We observed another person asleep all morning. Staff said they were nocturnal and did not sleep at night but no attempt was made by staff to engage them in anything or ensure they remained hydrated.

We spoke with the person providing activities who told us things had improved. We noted around the room were different things/games which could be used to help entertain people. The ground floor had a number of budgerigar's and hamsters which staff said people enjoyed and we saw one person holding them. They told us the previous week they had a visit from a travelling zoo where people were able to hold/interact with small animals. They referred to a new initiative which involved a local relationship with the college so that students came in and befriended older people. They had up to two to four students visiting, (daily) in the afternoon and the weekends which was said to enhance the levels of interaction and stimulation for people. The activity person told us care staff assisted them with activities and there had been a shift in terms of activity being everyone's business.

In addition a shop/café was being put in place which would be run by staff. Improvements to the environment and tactile objects along the wall and personalisation of people rooms to help them recognise them had been achieved. Staff told us the students were painting a muriel on the walls.

We saw staff managing situations well when people were shouting and disturbing others and when people were resistant to personal care. However when we looked in people's care plans there was not a lot of information about some people's needs. So for example, we identified a person who really did not like

baths, we saw in their care plan that there had been T no exploration of what their preferred routine was or if there was anything which might help to reduce their anxiety/stress around their personal care needs. We saw that their care plan referred to up to four staff to assist them with personal care for which there was no explanation and could be seen as oppressive does not appear to respect the person's dignity.

For the same person their care plan said they walked with a frame but were not able to during our observation so were given a wheelchair. This was not clear within their care plan. We saw that they were wheeled backwards as they did not have foot plates on the wheelchair so it was safer to go backwards. This was not appropriate and wheelchairs should always be used with footplates to ensure people are moved safely.

Although staff were interacting with people and were kind we did not see much to help people in terms of their communication or supporting them with their day to day activities. For example one person without verbal communication was clearly understood by some staff but not others and we did not see anything in place to help them express their frustration or make positive choices. Another person constantly walked around the service and the reasons for their behaviour was understood but there was no attempt to engage the person in anything which was meaningful for them. We looked at their care plan and saw they did have a life story in place and showed they had held down a professional career for many years. However their life story had been recorded up to their retirement and nothing since or how the service continued to engage this person in their interests and passions and stay reconnected with their past.

The dementia care unit had a lot of visitors and a volunteer during the inspection which meant some people received a lot of positive attention and staff were noted to be welcoming and friendly to visitors. The atmosphere was relaxed.

We looked at number of people's care plans and observed care being delivered to make a judgement as to whether care was effective and appropriate to people's needs. We found some really good information but also some information which was not up to date and not always reflecting the care that was being provided to people. For example we saw some good documentation around whether a person had capacity to make their own decisions or if they needed support and if so how this would be evidenced and who they would consult with. There was a form for each person 'clinical hot spots' which meant we could see at a glance what the persons main needs were and also what their preferences were in terms of resuscitation should it be necessary. We found other documents in place but not completed such as thinking ahead- (how people would like their end of life to be managed and their preferences around their death.) People's life stories had not been completed in all instances and these was not detailed guidance around key issues such as communication plans for people without verbal communication and, or dysphasia. We did find some communication plans, but one stated the person needed a hearing aid. They did not have it in their ear. The person told us it had been lost and they were waiting for a new one.

There was limited information about behaviour and how to support people with key aspects of their care. We found that notes did not always run in chronological order and it was not always possible to see what actions had taken place or if they were sufficient to reduce risk. We also found some information contradictory which made records unreliable. For example we saw a chronology of falls and an updated risk assessment but there was no exploration as to why the person was falling or if the steps to minimise the risk was adequate. For the person who had a number of falls, their falls risk assessment had been updated but their manual handling plan had not been which could mean they were not getting the support they needed. Their risk assessment said any further falls should be referred to the GP or falls team but their records did not show if this had happened.

Weight records were not consistently recorded and we could not always see actions taken. Information was recorded in different places. For people who had lost weight we saw that there were a number of recommendations but could not see if interventions were successful because we saw for some further weight loss. However for others we saw snacks being provided in between meals and people being encouraged to drink at regular intervals but this did not occur for everyone.

We had information about a person who had lost weight. Their manual handling plan had not been updated which resulted In them slipping out of the sling as the sling was now too big for their needs.

We discussed our concerns about records with the manager and regional manager who initially told us twelve care plans had been fully updated and audits had been carried out to ensure the accuracy and the thoroughness of this information. Evidence of this was provided. They also said risks in each care plan had been identified and updated but this was not consistent with our findings. We chose care plans by observing the care and identifying who we wished to case track.

We identified continued breaches with Regulation 9 person centred care although records were improving.

Following the previous inspection we received concerns about how people's personal care needs were not being met with people being left in bed for long period s of time and not always getting the personal care they should. At this inspection people were receiving personal care according to their needs and we saw people were well groomed. The manager said that staff were required to assist people up unless there was a clear reason not to. We saw that people were offered baths but the frequency should be reviewed. We saw for one person who said how much they loved their baths did not receive a bath very often and sometimes had to wait for more than a week. It was not clear from their records if they declined.

Our expert with the persons consent observed personal care given to a person and noted staff preserved the person's dignity and communicated effectively with the person throughout. They assisted them with their manual handling correctly. However the person became breathless and staff required prompting in how they should support this person appropriately. . Following our last inspection concerns were raised by whistle blowers that people were not appropriately supported with their personal care and did not have for example their teeth cleaned or hair brushed. Staff observed washed, dressed and supported this person appropriately including applying cream and brushing their hair and cleaning their dentures. The person was then asked what they would like to do go into the lounge or stay in their room. However we did note one hair brush fully mated with hair.

We spoke with relatives one of whom told us they were happy with the care that their relative was receiving, they said they were pleased that their relative was having baths as at their previous home they didn't.

We spoke with a number of relatives. One told us they had consistently raised concerns and had felt under previous management that these had been listened to but not responded to appropriately because they would happen again. They were confident in the acting manager and felt they were proactive and would listen and act. Staff also described the manager as fair and praised staff when they did well but was not afraid to challenge poor practice. The relative was understandably anxious that the service should continue to improve without further setbacks. The service had a complaints procedure and the one complaint recorded had been dealt with accordingly and in line with the complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2015 we identified a breach with regulation 17 clinical governance and the overall management/auditing of the service and records. At this inspection in April 2016 we found that the registered manager had recently left and both the acting manager and the deputy manager were new to post. The acting manager had been instrumental in working alongside the registered manager for some months so was familiar with families and people using the service. A previously employed member of staff had returned to their employment and was supporting the deputy manager and helping review care plans. They knew the service well. The acting manager told us they were well supported by their manager and the resident experience manager who was also new to post. Since the last inspection three registered nurses had left so clinical oversight of the nursing care was provided by the deputy manager. Unfortunately although significant progress had been made in terms of recruiting to care vacancies there was still a significant amount of un-recruited nursing hours, (176) hours a week.

We spoke with people about the service and they were mostly complimentary. Some knew the manager had resigned and they had contact with the new manager and knew who they were. However when asked who they would raise concerns with, one person said, "With one of the older members of staff. "

The acting manager told us this month there was a day's training planned for all nursing and senior staff to discuss accidents, incidents, medication and roles and responsibilities which we did not find particularly well defined during our visit and found staff were accountable for different tasks but did not always understand what their responsibility entailed.

We noted that since the last inspection things had improved in terms of staff feeling more settled and well supported by the new manager. The atmosphere in the service was positive and staff said the acting manager was very proactive and would help staff with providing care to people as required. There had also been changes to the environment which we found to be clean in most parts and visually stimulating. Care had improved in terms of people's experiences particularly in relation to their personal care and level of activity. This had been boosted recently by the numbers of students volunteering at the service. In addition the family support at this service was tremendous and gave a real boost to the service and enhanced people's experiences. Relatives told us the service was on the way up, with more staff, improved personal care for their family member and a manager and deputy who were responsive to their concerns/feedback. One relative said about the manager, "Marvellous, works really hard." Another relative told us communication required improvement. They said they had not been notified when the manager left or what the new management arrangements were. They also said when they had raised issues in the past these had not been responded to which we found was the experience of a number of relatives.

Staff spoken with were enthusiastic about the improvements they had seen in the service. They told us the home had real potential which we recognised. They said communication had improved with the introduction of the flash meetings which were held daily involved all staff and focused on what was happening and the service and any risks. They said they had more time to spend with people and care was more individualised and people were more engaged and able to go out with more trips planned. They

described the service as having a family atmosphere and people using the service being like family members. One staff said. "We think we are brilliant." Another said "Friendly staff, good company to work for."

However we did have some concerns about the service and the slow progress being made particularly in terms of people's records being updated which should inform staff about how people's needs should be met and what was in place to mitigate risks. The Regional manager said that we had looked at care plans which had not been reviewed but these were selected at random and highlighted some fairly substantial concerns. Risks were not being managed proactively.

We spoke with staff and in particularly staff leading the shift. Some senior staff were fairly new to their post and to the floors they were working on so were not able to tell us about everyone's needs and in particular immediate risks to people. The Assistant Practitioner leading the first floor had received additional training for their role but was not working along- side a nurse.
The Assistant Practitioner was new to post and should have a Registered Nurse working alongside them to mentor and support them in their practice, so that standards are raised and maintained. The Deputy Manager cannot do all of these roles alone. On the day of our inspection the Deputy Manager was the only qualified nurse with an up to date professional identification pin number. We judged that people on the day of our inspection were not getting effective nursing care. No Registered Nurse appeared to be taking responsibility for the planning or delivery of nursing care. This means that frail elderly people with complex needs, such as pressure ulcers or weight/nutrition management were not receiving timely interventions. Carers were not fully aware of what the care plans contain and how best to support the person safely.

Given the levels of concern with this service we asked the acting manager how much they had engaged with relatives. We saw the last report and ratings was displayed in the home as required by regulation. The acting manager said they were there daily and at the weekends when needed and always made themselves available. This was confirmed by relatives. They said they held three monthly meetings but was considering changing this to monthly. The acting manager showed us compliments received about the service and felt they had turned a corner in gaining people's confidence. They said there were no outstanding complaints.

We have received information from at least four whistle blowers since the last inspection giving us information of concern about the service. Any known concerns have been raised and investigated by the safeguarding team but without specific information it is not always possible to know about specific concerns or the timeliness of the information. The acting manager was asked how they ensured staff understood their responsibilities about raising concerns and to whom they could raise concerns too. A number of staff had said when they had raised concerns previously these had not been addressed by the management team. This was discussed with the Regional manager who told us the organisation had invested in an external whistle blowing line where staff could raise their concerns anonymously and in confidence. This meant concern could be responded to by the Regional manager. We did not look to see if any feedback had been received.

There were other ways the service used to engage people's and staff's feedback to improve the service as required including i-Pad around the service where people could give their immediate feedback which would be required to be signed off by both the acting manager and regional manager to show what actions they had taken in response to feedback of concern. The resident experience manager was employed to enhance people's experiences and support staff in giving people a good quality of life. Questionnaires were also used. The acting manager said feedback of care websites was positive. We asked the acting manager about any examples of actions taken as a result of feedback. This included including redecoration all of upstairs corridors. The car park had been extended. Review of pay scales and staffing levels at the weekend, this has

been looked at and the skill mix has been changed at the weekend. If no senior available then the manager, Deputy or clinical lead will be on site both days.

We questioned the effectiveness of previous quality assurance systems given the number of concerns we have highlighted in this and previous inspections not identified by the service. We also received information from a whistle-blower relating to one person's care and an incident that had occurred. This information had not been shared with us by the service and requests for additional information were not forthcoming in a timely way. Unfortunately the standard of past record keeping was poor and hampered appropriate investigations being conducted. We also received concerns from the safeguarding team in relation to a recent investigation and the way it was managed.

This was a continued breach of Regulation 17 clinical governance.

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This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care based around their assessed needs and wishes and records were ambiguous.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12.2 (b) The service did not protect people against the risks by way of doing all that is practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not adequately supported with their nutritional and hydration needs and there was inadequate monitoring of this. Regulation 14 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulations 2010 Premises and equipment. The premises were not clean or suitable for use. Regulation 15 (1) (a)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17.2 (c) The service did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services and others were not always supported by sufficient numbers of staff who had the necessary support and skills to be able to deliver the care effectively. Regulation 18 (1) (2) (a) (c)