Bupa Care Homes (CFChomes) Limited

# Hatfield Peverel Lodge Care Home

## Inspection report

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22 June 2016

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## Ratings

| Overall rating for this service | Inadequate |
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| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

Hatfield Peverel Lodge Nursing Home provides accommodation, personal care, and nursing care for up to 70 older people. Some people have dementia related needs. The service consists of Mallard House for people living with dementia and Kingfisher House for people who require nursing or residential care, some of who may also have dementia and other complex health condition. Kingfisher house was split over two floors, with the top floor being named Robin.
The inspection was completed on 21 and 22 June 2016 and there were 61 people living at the service when we inspected.

A home manager had been seconded into the post with daily telephone support from the registered manager who had been deployed elsewhere within the organisation, but who had retained overall responsibility for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service has been inspected at regular intervals over the last two years due to concerns that people were not receiving care that was safe, effective, caring, responsive, and well led. We identified a number of concerns during the inspection on 19 March 2015 and 17 April 2015 where we found that the provider was not meeting the requirements of the law in relation to consent to care and treatment, staffing levels and the arrangements for quality assurance were not effective and improvements were required. An additional inspection in October 2015 identified that some improvements had been made, however there were still areas of improvement needed in medicine management, staff supervision, and quality assurance systems. The plan provided by the service had not insured that all improvements were made.

During this inspection, we found that improvements that had been made had not been sustained and that issues that remained had not been addressed effectively for the safety of people using the service. We found that quality assurance systems in place did not identify that people nursed in bed were not receiving timely care and treatment and that records to document care needs were not filled in at the time of care provided. We found that there were not sufficient systems in place to identify the safe level of staff needed to manage the dependency needs of people at the service.

We identified a number of concerns about the care, safety, and welfare of people who received care from the provider. We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to this provider and will report on this when it is completed.

We found that staffing was not sufficiently employed to meet peoples individual needs to promote independence and physical and mental well being and safety. We found lounge areas on Mallard unit at times unattended in spite high risk activity, and people nursed in bedrooms went without regular meaningful interaction for long periods.

When risks to people were identified, interventions to manage these risks were not always in place.

Systems in place to monitor and accurately record peoples dietary and nutritional intake were not always followed correctly. Consequently, in was difficult to ensure accuracy and consequently individual's level of risk and need.

Some staff we spoke to had a poor understanding of people's rights under the Mental Capacity Act. People told us that due to the restraints on staff time they did not always have care provided in a way that respected their capacity to make decisions or their wishes.

Whilst we observed a number of positive and caring interactions between staff and people at the service, we observed some interactions from staff and people were not caring or dignified.

Some care plans were task orientated and did not focus on the individual person they were designed for.

Staff told us that they did not record all complaints made to them, for example the loss of sensory aids. We found that in some cases it took considerable time to address these issues, leaving people sensory deprived for longer than necessary, even when this had been highlighted in risk assessments as a potential risk factor for falls, mental ill health and loss of independence.

Where internal audits had identified areas of improvement were needed, action plans did not include how changes would be implemented or when they should be completed by. A number of issues identified by the provider had still not been addressed at the time of inspection.

Consequently, the overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' Services in special measures will be kept under review. If we have not taken immediate action to propose to cancel the provider's registration of the service, they will be inspected again within six months. You can see what action we told the provider to take at the back of the full version of the report.

The expectation is that providers found to be providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe

The service did not always assure that risk assessments contained legible and meaningful interventions to support staff to minimise risk to people when identified.

People at risk of poor mental health and social isolation did not receive appropriate support.

Staff did not always encourage people to remain independent for as long as possible.

Staff were not always visible in communal areas on Mallard unit and people were put at risk of unobserved falls and incidents.

### Is the service effective?

**Requires Improvement**

The service was not always effective

Managers did not use supervisions to identify, monitor, and manage staff when issues had been identified with practice.

Systems in place to ensure that people received adequate nutrition and fluid were not always followed.

Recommendations from visiting professionals were not always followed through.

Staff had poor understanding of the Mental Capacity Act (2005) and DoLS best practice was not always followed.

### Is the service caring?

**Requires Improvement**

The service was not always caring

Staff did not always treat people with dignity and respect.

People were not always involved in their care.

However, relatives and people at the service told us that most staff were caring and did the best they could.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive

Care plans not always person centred and task orientated.

Staff did not respond to people's needs in a timely way to minimise risk of sensory deprivation and social isolation.

However, there were pleasant spaces for people to sit with loved ones and the service had a flexible visiting times.

## Is the service well-led?

**Inadequate**

The service was not well led

The provider had not sustained improvements previously made following concerns at the service in 2015.

There was not sufficient oversight of staff and the quality of care provided.

Processes in place to monitor the quality of the service identified concerns that had not been addressed at the time of inspection.

The home managers had not assured themselves that staff were supporting people safely.

# Hatfield Peverel Lodge 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.

This inspection took place on over two days on the 21 and 22 of June 2016 and was unannounced. The inspection team was made up of two inspectors, and a specialist advisor with experience of working with people who have dementia.
Before the inspection, we examined previous inspection records and notifications we had received. A notification is information about important events, which the service is required to tell us about by law.

We spoke with 14 people who used the service, eight relatives, six members of care staff, the registered manager, the deputy manager, the unit managers, and the area director. We looked at the care records for 14 people, including their care plans and risk assessments. We reviewed 10 people's medication charts. We looked at staff recruitment files, minutes of meetings and documents relating to the quality monitoring of the service, including complaints and complements, and incident recording and a variety of clinical audits.

Inadequate

# Is the service safe?

## Our findings

Heads of care and senior nursing staff carried out risk assessments for people at the service and updated these monthly. However, these assessments were at time of inspection illegible, incorrect, incomplete, and without instruction to staff as to how to manage the identified risk.

We saw that a number of assessments and reviews had highlighted that people were at risk of depression and low mood. These indicated that isolation might contribute to this risk. For those who were at risk of isolation compounded by sensory deficits, such as poor hearing which might contribute to feeling isolated, it was repeatedly documented that staff should maintain hearing aids and ensure that people had these on. However, in two cases on Kingfisher unit, people with this risk had not had access to their hearing aids for up to three months. This was not reflected in the care plan.

Depression scales were used to monitor people's mental health, but when people were highlighted as severely depressed, there were no interventions for staff to follow, or instructions for staff on how to identify if a person's mental health deteriorated. When these people were on medication for depression, there was no record of this in the care plan, so staff would not know to monitor for changes. There was no recorded input from mental health services or psychological therapies.

The lack of how to support people who had been identified as at risk of depression had been an issue that had been identified from a quality audit carried out by the service in May 2016. However, no measures had been taken to rectify this and we saw that no robust plans were in place to manage this in the immediate future.

Risk assessments and interventions varied in quality through each person's care plan. We saw some that were person centred and that had clearly involved the person and their loved ones. However, in the majority they were task orientated, and did not identify how to support the person to overcome risks in a way that promoted their independence.

Staff told us that they did not have time to encourage independent mobility for people who were at increased risk of falls. A relative told us that their loved one's mobility had decreased significantly following a series of falls and that they were afraid to walk. This was confirmed within the care plan, and interventions informed staff to support the person to build up their confidence.

However, staff told us that they did not always have the time to do this so they used wheelchairs. The potential consequences of this would be that people would then need additional staff support. They would be at greater risk of developing pressure ulcers through poor mobility and lack of movement, increased incontinence risk, increased pain from stiffening of joints and the associated feelings of helplessness and potentially low mood due to the high reliance on staff for everyday needs to be met.

We saw people on both units being moved and transferred in armchairs on wheels. Whilst these chairs are designed to move people, staff told us that these people did not often come out of these chairs, for example

to sit at the table. One of these people had to be wheeled backwards due to their feet dangling close the floor and causing a risk of trapping their feet. The moving and handling care plan for this person indicated that they should be hoisted from the chair into other chairs, such as a dining chair and that repositioning was important. However, staff told us that they did not have time to do this. BUPA's own quality audit in May, identified staff were not recording that people who lacked mobility were being repositioned in communal areas and that this needed to be done. However, there was no clear plan of action and we did not see that the situation had changed during our inspection.

On both days of inspection, we identified instances where people had not been protected from the risk of significant harm. We saw that there had previous been complaints from relatives that people were left unattended in communal areas. A person on Mallard unit presented as a significant risk of causing distress to others, constantly interfering with others, pulling at their clothes and snatching their belongings. Yet measures had not been taken to protect either them or others from the risk of abuse. For example, we spoke to staff about the person who told us that they were aware of this person's behaviour, the potential risks associated with it, yet on numerous occasions during both the 21, and 22 June, communal areas were left without staff in attendance.
During these times, we observed this person interfering with and causing significant distress to others. Staff did not ensure the service user was engaged in activity to distract them from interfering with others. We observed people begin to shout at the person to leave them alone. On one occasion the person took someone else's drink and drank it. There was a significant risk of the person being assaulted, being pushed and injuring themselves and of them assaulting others.

Many people nursed in bed had bedrails in place to prevent them from falling from their bed. However, in one risk assessment that we reviewed where bedrails were being used it had been highlighted as not to be used due to the risk of the person trying to climb out. It was not clear how these risks had been mitigated. BUPA's own quality audit carried out in May identified that "Actions were not always recorded to justify the risk management with regards to bedrails when the tool advises against their use for some residents." However, no action plan was in place or recommendation to address this issue or to explore alternatives to bedrails. This potentially left people using bedrails at risk of falling from falling from a height and injuring themselves.

We saw that when people had been identified as at risk of agitation and behaviours that challenge that either had the potential or could potentially result in aggressive behaviour, that care plan interventions did not give staff clear instructions on how to manage people. For example, on Mallard unit a person was identified as being a risk of presenting in an agitated and aggressive manner. The care plan informed staff to distract the person and to "Help [person] to make their days meaningful and active. " However, the life style / activity care plan did not evidence any interests or hobbies, and nowhere in the care plan told staff how they could distract the person with what they liked to do.

Some care plan interventions to manage peoples identified risks were illegible. We saw from all the care files we looked at that, these had been an issue for many months. We spoke to the home manager who told us they were aware of the issue, and were managing it; however, we found this was not the case due the significant period of time that had passed and that illegible hand written entries continued to be made without redress. Staff could not read much of the writing and therefore would not have the information they needed to address risks identified safely. Following the inspection, we wrote to the provider and asked that all these records be immediately addressed.

Kingfisher unit is a nursing unit and service users were generally more dependent on staff to meet their needs. Two service users told us that they were in a lot of pain most of the time. One relative told us that

their relative was in a lot of pain. Staff had recorded in the persons care records that they were complaining of pain and this had prevented them from mobilising, and we saw that pain risk was identified in care plans but action had not been taken to review their medicines or carry out regular pain assessments.

On Kingfisher unit, we found that five of the seven medication administration sheets (MARS) reviewed for people who had health conditions where they experienced pain and were prescribed significant pain relief including controlled drugs; did not have pain assessments in their care records to instruct staff on how to manage people's pain and discomfort. A quality audit completed by BUPA on the 19 May 2016, identified that there was a "Lack of pain tools in place for residents on PRN (as required medication) and regular analgesia," but no recommendations had been made to address this and consequently management of people's pain remained poor. We saw that in the corresponding care plans for three of the people that pain had been identified as a significant barrier of living well. The quality of life for these service users was substantially reduced because staff did not manage their pain effectively.

Medications were not always managed safely on Kingfisher unit. The provider had an audit sheet for staff to complete at the end of each medication round to ensure that people's medication charts had been signed and medication dispensed. However, we saw from the records that this had not been done since the new audit sheet had been started, five days previously. The nurse told us that they did not have time to complete it. Nurses told us that they were often interrupted when trying to dispense medication by the telephone, visiting professionals and staff. This meant that they were trying to concentrate on numerous tasks instead of focusing on people receiving medications. It also meant staff would potentially not see if they had made errors.

We asked qualified staff about specific medications they dispensed from MAR sheets, but they did not always know what these medications were. Whilst they did have access to a British National Formulary (a medication index) they had not checked in that formulary what medications were for and whether they needed to observe for any complication's due to the medication, such as toxic malignant syndrome, a rare condition that if undiagnosed can cause death. We saw from MAR sheets that staff had regularly dispensed this medication for some time. We saw two handwritten MAR, which were illegible, but because staff dispensed medication from blister packs (pre packed medication with time and date dispensed by a pharmacy), they did not consider this an issue relying on the pharmacy in being correct. Consequently, we could not be confident that qualified staff were administering medication safely, or had considered the impact of illegible records in line with their own professional code of conduct.

The Medication audit on Mallard unit demonstrated that when information about medications were missing, such as a signature to state it had been given, the action was to record the information "ASAP", rather than to specify a date, which meant there was a lack of audit trail to follow things up. People are potentially at risk if they have not received the medication prescribed to them.

On both Mallard and Kingfisher units we saw incidents of people on PRN (as required) medicines for agitation, however, staff did not record why PRN medication was given, and whether it had reduced a person's agitation. This meant they would not be able to review the need for the medication appropriately in line with their PRN policy.

We found areas of the home, which should have been locked in order to ensure the safety of people had not been secured. This included the boiler room, and two cupboards containing electrical switchboards. In the boiler room, we found two hand held cordless drills lying on the floor. We addressed this with the home manager on the day of inspection and they immediately addressed the situation, caused in part by external contractors carrying out maintenance work.

Staff did receive infection control training, however we saw that best practice was not always followed to prevent the risk of cross infection. We found that the sluice room was unlocked and accessible to people throughout the day. Inside the sluice room, (a room dedicated for the cleaning of human waste), we found five commode pots that were dirty with dried faeces, and we could see dried faeces also covering the roll of new clinical waste bags. These were present throughout checks during the day. The manager immediately addressed the issue with staff.

On Kingfisher's upstairs corridor 'Robin,' we found used dressings left on the side of a bath in a communal bathroom. We found a hoist sling draped over a toilet seat in a person's ensuite toilet. A set of bedrail bumpers that were worn and fraying, although the services quality audit in May 2016 identified that some of the bed bumpers needed to be replaced. We saw that some people's commodes still had faeces on them and that a number of hoist slings appeared to be stained. A member of staff told us there were not enough slings to go round so that people had to share. We asked when the slings were washed, and were told by staff when they looked dirty.

In three bedrooms, we found topical creams left on the side of sinks, without dates of opening and with tops off. One top was found down the side of a toilet. This increased the risk of contamination and infection. We could not be certain that people were following the correct guidance on how to administer topical creams to individuals as prescribed as cream charts were kept with MAR sheets and the creams were kept in people's bedrooms. In the quality audit carried out by BUPA in May 2016, they had also identified an issue with topical creams, however, we could not see that any actions had been taken to address concerns. We could not be confident that staff were adhering to infection control best practice that might prevent risk of cross infection.

This is a breach of Regulation 12 (1) (2) (a) (b) (e) (g) (h) HSCA 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

We found that there were not enough staff on duty to meet service user's needs effectively. Whilst staffed to their full allocated establishment, staff still struggled to meet people's needs in a safe and timely manner. The manager told us that they did not use a dependency tool to calculate the right level of staffing to meet people's needs. Rather, they were calculating this based upon the numbers of service users on the unit. On Kingfisher, including Robin unit, service users had a high level of physical, social, and emotional need. Staff told us that dependency levels of people were not considered before admission to the service, in regards to the existing level of dependency within the home, and whether staff could manage people's needs.

Staff told us that they relied on the night staff to get people washed and dressed and the night staff would hand morning staff a handwritten note to state that they had "done." We did not see that this was recorded within the handover sheet, and care plans did not document whether it was peoples preference to get up early. Nursing notes did document that people were assisted with person care by night staff, however this did not demonstrate that people had been asked if this was their preference. Staff told us they would be unable to get back to check on these people until late in the morning after everyone else had received care. We observed staff still helping people to get up at lunchtime. This issue had been highlighted during an inspection in March, 2015. In spite of an action plan, we continued to find this to be an issue.

On both days of our inspection, we observed that many service users remained in bed late into the morning and had not been helped to get up. Staff told us that this meant people often waited for essential needs such as going to the toilet. Staff also told us that they did reposition people in bed when supporting them with continence needs and they tried to reposition them at other times, however this was not always in line with care interventions in the care plan. This was particularly difficult to complete during the morning when

people's physical care needs were high which meant that people were at increased risk of developing pressure ulcers. In addition, this lack of contact left people in their bedrooms social isolated. This was identified as a risk in people's wellbeing assessments and people told us they felt lonely. Consequently, people risked increased mental health problems such as depression and anxiety.

This is a breach of Regulation 18 (1) HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

Staff working at the home had all undergone enhanced DBS ( Disclosure and Barring Service) checks to ensure that they did not have records indicating that they would be unsafe to work with vulnerable adults. We saw that the provider had followed their recruitment policy and staff had received two appropriate employment and character references, prior to being offered a post.

Staff received training and training updates in safeguarding vulnerable adults. Whilst some staff were out of date, we were assured that they were booked onto upcoming courses. Staff told us they would not hesitate to inform the home care manager if they thought that people were at risk of abuse and were aware of the whistle blowing policy and the independent BUPA "speak up service." A hotline dedicated to staff to speak up against abuse.

Requires Improvement

# Is the service effective?

## Our findings

The service had received additional training and input from PROSPER, (Promoting safer provision of care for elderly residents) a local authority better health partnership, and they had implemented some of the tools and training. On the day of inspection, they had received a recognition award for their work in relation to fluid and hydration activities. However, we identified that service user's nutrition and staff were not always meeting hydration needs, and that risks associated with malnutrition and dehydration had not always been acted upon.

We observed that a number of people were in bed most of the day on both Kingfisher and Mallard units on each of our inspection visits. We observed six people in their bedrooms on Mallard unit. All of whom had their drinks positioned out of reach. On Kingfisher unit, we identified a person who had a drink that had been placed out of arms reach so they could not drink it independently. There was tea spilt on the floor by the person's bed. The cup of tea was cold, yet it was recorded in the fluid notes that the person had taken 200mls of tea two hours before. The service user told us, "That's the only trouble with staff, I rarely get given a drink outside of meal times because they are so busy."
Staff told us they could not get to people to offer drinks when in their bedrooms, other than set drink times.

People on Mallard unit whilst nursed in bed did have nurse call buzzers but these were out of reach, staff told us that people were unable to use them due to their level of confusion. This meant that people had to rely on staff to come to them to provide drinks. Bedrooms were very warm and in five of these bedrooms, windows were closed. The service did not monitor room temperatures. People were at risk of dehydration and associated ill health.

Supplementary records detailing when people had taken fluids and diet forms were not filled in as tasks were completed. Staff told us they filled these in at the end of day and that they guessed what times they had turned people, and when they had received drinks and meals. Those nursed in bed were also high risk of receiving pressure ulcers. Part of the preventative treatment for pressure ulcers is to ensure adequate hydration and nutrition.

Whilst there was a varied choice of good home cooked food, which was tasty and nutritious, people had to make the choice of food 24 hours in advance. This does not support people with dementia to make choices. One person told us, "I might change my mind the next day, as I might fancy something else." Staff told us that it sometimes caused problems, particularly for those who had dementia and could not remember what they had requested. On member of staff told us, "I mean you see someone with a sausage roll and they think I want that, but they can't have it as they didn't order it the night before. Sometimes it can cause difficulties as they will try and take it from other people, and they don't remember they have already chosen."

The dining experience for people on Mallard unit was a poor. Tables were bare and people were not always sat together or with staff. There was little social interaction, although we did see one member of staff siting with a person and chatting. Staff told us that they did not dress the tables because people were confused and might move things. There had been little effort to consider how best to make the dining experience

enjoyable for people with dementia. Meal times were task focused and staff we spoke to referred to people who needed assistance as 'The Feeds.' We did not see evidence that people's individual needs had been addressed.

This was a breach in Regulation 14 (1) of the Health and Social Care Act, 2008; Fluid and Nutrition.

Qualified nurses in charge told us they did not always have time to provide direct care to service users and that they relied on trusting the care staff. One nurse told us that this meant that they could not assure themselves of the competency of staff.

The heads of care carried out individual staff supervisions every other month. We saw evidence from the five staff files reviewed and supervision records that one member of staff had been identified as not performing in line with expectations but it was unclear how the head of care and home care manager were monitoring them for improvements. Qualified staff told us they did not have time to oversee care staff. Some staff had not completed their induction workbooks, in spite of being at the service for more than six months.

We observed some staff interactions that had the potential to agitate and distress people, where staff dismissed people's requests and spoke to them in an antagonistic manner. Supervisions did not adequately address concerns about individual staff practices.

We found that people on Mallard unit did not always have the appropriate equipment to maintain good oral hygiene. For those that did have equipment such as toothpaste and toothbrushes, we found that these were not always used. For example, dry toothbrushes and unopened toothpaste. Staff told us one of the most common complaints from relatives was about the lack of good denture care, for example, clean dentures or dentures in place. This can affect a person's ability to eat, and lack of good oral hygiene increases the risk of mouth ulcers and poor physical health.

Staff had received mandatory training on the Mental Capacity Act 2005 (MCA). The 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. However, staff we spoke to did not have a good understanding about assessing people's capacity to make decisions. For example, one member of staff told us, "We make the decisions for residents when we give them care that is in their own best interests." Examples of this was when people wanted to get up or go to bed.

When we reviewed peoples care notes staff did not always state how they had supported people to make choices about their care. BUPA's own quality audit in May 2016 highlighted that some staff had a poor understanding of MCA and they were consequently addressing this with additional training.

Staff also received training in Deprivation of Liberty Safeguards (2009). DoLS provide legal protection for people aged 18 and over who are, or may become, deprived of their liberty in a hospital or care home. We saw that people were being referred for DoLS, however on the day of inspection we found that one person was not subject to appropriate mental capacity assessments and application for DoLS. The home manager took immediate action to address this upon inspection feedback.

Where people were at risk of poor nutrition, this had been identified and appropriate actions taken. People were regularly weighed and MUST (Malnutrition Universal Screen Tool) assessments were carried out. Where appropriate, referrals had been made to a suitable healthcare professional, for example, where a person had

been identified as being at risk of swallowing difficulties, a referral to the local Speech and Language Therapy Team had been made so as to ensure the person's health and wellbeing.

The service did hold six monthly review meetings with the GP and pharmacy for medication reviews. Care plans demonstrated that advice from the GP surgery other professionals were sought then the need a rose However, we could not always identify what advice had been given and what the professional had visited for, as in some cases the written entries were illegible.
On Mallard unit, staff did not always follow up recommendations by visiting professionals. For example, in one case we saw that a tissue viability nurse had visited a person in April who recommended that they receive a podiatrist visit due to pressure areas on feet and diabetes.
However, there was no record of this happening, yet we saw that another professional recommended the same thing for the person two months later.

We asked staff on Kingfisher unit how they followed up on people's needs, for example when recommendations were made for health care appointments or when hearing aids / dentures and glasses needed attention and they told us that they just handed it over to each other. On Kingfisher unit the communications book was no longer used, and staff told us "we don't use that anymore," This meant that staff could not always keep track of people's needs in manner that effectively met their health needs.

Requires Improvement

# Is the service caring?

## Our findings

Despite people telling us that they felt cared for, we spoke with staff, carried out observations of people and staff and found that the service required improvement in this area.

People were not always involved in their care. Staff told us that they made the decisions based on what was best for the person at the time, but we did not see how they evidenced this. We saw examples when staff dismissed people's requests, even when the person had capacity to make their own decisions. The home had carried out a quality audit in May and identified that "There was some lack of written evidence to show that residents and relatives were involved in the care planning process, however when discussed with residents they felt they had the option to be involved in this area should they want to." However, although this was identified we did not see any written evidence in case notes that people and relatives had been included, or been given the option to contribute to care interventions.

We asked staff to tell us about people in their care and found that they had a fair knowledge of peoples personal history likes and dislikes. However, we observed two interactions on Kingfisher unit that were not caring in manner, one of which was provoked an increased agitated response from a person in distress and another that dismissed a person's needs and requests without taking the time to listen to them. We discussed this with the manager who spoke to the member of staff, however, the registered manager acknowledged that this was the carers "style" of communication, and did not address these issues to improve and develop staff skills citing that this person was one of their best carers. Failure to address this style of communication means that staff will continue to perpetuate poor practice and speak to people in a way that is not always dignified and potentially placing people, including staff at increased risk of violence and aggression.

We observed that interactions with people with dementia were not always caring. On Mallard unit, we observed a member of staff attempting to engage a person within an activity of cards. However, they waved the cards in front of their face, before stating to the person, "You can't really see these can you," then walked away to speak to someone else. This was not a respectful or dignified interaction and left the person confused. The member of staff did not seem to know how to best engage with people with dementia.

Privacy and dignity was not always maintained. We observed a number of interactions and episodes when people were not supported that resulted in resulted in a lack of dignity and privacy for those people. The services own quality audit in May had identified an example of this, however there was no evidence that measures had been taken to address these issues other than recommendations to supervise the member of staff following the incident. There were no time scales or plans in place to ensure that the incident would not be repeated, or discussions with staff to ensure that the practice was not commonplace. Consequently, the service did not demonstrate that they were learning from incidents that affected people's dignity.

People were not always involved in care planning. We did observe that staff were recording in care plans that people had agreed to care interventions and we observed that in some care plans staff had stressed the importance of informing people about care interventions as they occurred. However, we did not see that

people signed these themselves, so could not be assured of their involvement. For people who lacked capacity we did not see various best interest assessments that might have included advocates and relatives who held power of attorney over the person's health and wellbeing.

However, we also saw some very positive caring responses to people. On Mallard unit, we observed a person stating they were cold. Staff quickly closed the window and when told they were still cold, fetched the person a blanket, comforting them and assuring themselves the person was now comfortable.

Relatives we spoke too told us that they were happy with the care provided. One relative told us, "It's a wonderful place; I could book my bed already." Another told us, "There are a few little niggles but on the whole they look after [Person] really well."

Requires Improvement

# Is the service responsive?

## Our findings

Staff told us that care provided to people was task led because of time restrictions on them to get things done and that there was not enough staff to meet the level of dependency of people's needs.

People told us that staff did not have the time to support them in all their needs and those nursed in their bedrooms told us they were isolated and alone. Care plans documented that people might be at risk of depression and but did not identify how to manage this risk when isolated in their bedrooms.

People that were nursed in their bedrooms told us that staff did not have time to spend with them unless they were supporting them with continence needs. One person said, "They are really lovely, but they can only come to see me when they change me. I get very lonely." Another person said to us, "Please don't leave me, I am so lonely, please stay, and talk to me." Staff told us that they tried to spend a few minutes in the afternoon with people, but as so many people were nursed in bed, they could only manage popping into one or two people, unless someone required help with their continence needs and they would have a chat then whilst changing them. Staff told us, "We do get to speak to people when we change their pads."

Staff told us that mornings were task orientated due to the complexity of people's individual needs and the time it took to support people. When we interviewed staff, they referred to people at times as a series of tasks. For example, they called people who required support with eating and drinking as, "The feeds," and those that needed support with continence needs as the, "Pad changes."

Some care plans were person centred, however in the nine care plans reviewed on Kingfisher unit, we found very little information as to how people had been included within the planning of their care. Staff carried out a system called 'resident of the day,' which meant that the nurse in charge would carry out a full review of a person's care plans. However, we found that in a number of different care plans information was incorrect, not up to date and had little evidence of involvement with the person.

Staff recorded that people had been involved in the reviewing care plan interventions, however we did not see peoples signatures to evidence this, and involvement was not documented in the care plans or clinical notes. Staff told us that in spite of recently receiving additional supernumerary time to complete care plans and other paper work, these were still reviewed in a hurry due to the amount of work they had to do. Consequently, there was no evidence that people had actually been involved with planning and reviewing care plans.

We found that people who had sensory impairments, such as sight and hearing difficulties, had assessments in place that identified they were at risk of isolation, depression, and risk of falls due to these disabilities. Reviews of these risks and care intervention's did not have clear guidance to staff as to how to manage the risks. For example, a simple statement stating, 'Staff to make sure hearing aids are in, and that these are maintained,', however, they failed to document how to maintain the hearing aids, for example who to contact if new parts or batteries were needed, or what to do if they go missing. Staff and relatives told us that this was a common complaint and relatives ended up dealing with it themselves. Staff told us they did

not know what to do if hearing aids went missing other than look for them. Some staff were not aware that hearing aids had gone missing. This meant that people would be sensory deprived for longer than necessary which would affect their social and mental well-being.

We found evidence that some people were left in bed because of the risks they present with in communal areas. One person who lived on Mallard unit spent most of their time in bed, although clearly enjoyed social interaction. The person's relative told us, "[Person] always seems to have dinner in bed. They are very short staffed here all the time." We observed that whilst the person ate unaided they would have needed a wheelchair to access the lounge or dining room. Staff told us if the person came downstairs' they would try, get up, and walk but were at risk of falls, so it was preferable for them to remain in bed with bedrails to prevent them from falling out. The relative said they had asked about [Person] sitting downstairs and was told by the nurse in charge that, 'Someone would need to pay extra to have a carer sit with him.'
The risk assessment did not clearly document how to support the person to maintain independence, and required to review opposed to leaving him in his room all day where he is isolated for contact with other residents. The relative had requested that staff contact social services to inform them of the persons increased needs; however, this had not yet happened. Some relatives we spoke with told us they did not know that their loved one had a care plan.

This is a breach of Regulation 9 (1) (3) (a) (b) (e) HSCA 2008 (Regulated Activities) Regulations 2014 Person centred care.

Both Kingfisher and Mallard units had variety of different pleasant quiet spaces where people could meet relatives in privacy and comfort. One relative told us, "It's like a palace here." We saw that people did use outdoor spaces with activity staff and loved ones, to take in the pleasant gardens and surroundings and flexible visiting hours. Relatives told us they liked these areas.

We saw that people's religious preferences were recorded in care plans, and that people could go to church and practice the religion of their choice.

We saw that general complaints were not documented, for example missing hearing aids, clothing, and lack of oral hygiene and dentures. Staff told us that these were regular concerns that relatives expressed and they would try to resolve them at the time. Where complaints were more serious, we saw that the service did carry out investigations into concerns and respond to people who had made complaints. However, we reviewed one complaint that raised a number of concerns about quality of care that a person had received leading up to and following a fall, including initial poor nursing observations following a fall and the monitoring of fluid and diet intake. During the inspection, we found that these concerns had remained and consequently we could not be confident that the provider had used the information from complaints to improve the service provided.

Relatives told us they felt they could raise complaints when they needed too, however, staff did not always act on them because they were too busy. One relative stated, "I made an informal complaint to a senior member of staff] and they apologised but nothing changed. It was only a minor issue so I let it go." □

Inadequate

# Is the service well-led?

## Our findings

We found that some of the improvements that had been made following an inadequate rating at the service in May 2015 had not been sustained during this inspection.

Effective auditing procedures and management oversight were not in place and consequently the service had not identified the shortfalls we found which put service users at risk. Therefore, the service failed to ensure that suitable procedures were in place for identifying monitoring and mitigating risks to service users.

The provider had carried their own quality audit out on the 19 of May 2016, which identified some of the issues we found during the inspection. However, a number of issues identified did not identify action points following this report. No improvement dates were given.

The home manager had not identified issues of concerns that we found which echoed some of the quality audit findings. It was unclear as a service how they were quality assuring the care provided. We found that some interventions within action plans developed following the inadequate inspection in May 2015, were no longer happening. For example, people being left in their rooms with limited input remained a concern. The action plan dated June 2016 stated that staff would have protected time for people, however when we spoke to staff they did not know when this was. They told us the only protected time is meal times.

The home manager was unable to demonstrate how the performance and competency of staff was measured so that areas for improvement could be identified. Audits and quality assurance checks carried out by the manager did not identify the issues we found during our inspection, including where service users were identified as being at risk of harm. For example, the home managers had not assured themselves that supplementary forms were being completed in line with policy. They informed inspectors that they had checked all the forms on the second morning and these were all up to date. However, we had identified during the previous day that these forms were not up to date and consequently had been filled in retrospectively. The registered manager agreed that retrospective entries were inappropriate and staff knew that they should not be doing this.

We could not be confident that was sufficient oversight of the care provided to people in their bedrooms and that care provided was inadequately monitored to ensure this vulnerable group of people received safe and appropriate care dependent on their identified needs.

The home manager acknowledged that the records were poor and they were aware of this issue, however had not taken measures to ensure that the care plans and interventions were legible. The manager held daily meetings with the heads of care and this included discussion of the "person of the day," a BUPA wide process to review each person's care plan. However, for every care plan reviewed, we found numerous illegible entries for many months.

The manager was given examples of our observations of staff interacting with people, however told us that

they felt that one of the carers was one of their best carers. This placed further concern as new starters are placed with carers who the management team identify as being good in their role. New staff did not shadow qualified staff and would be assigned to shadow another carer who was on duty. Consequently, new staff might be exposed to these behaviour's and ways of working with people which potentially reinforces a culture of staff that disregard peoples requests and who feel that it is acceptable to speak to individual people in a way that places them at risk.
We saw a complaint that raised concern that people were being left unsupervised in communal areas on Mallard unit and we observed this to be the case during the inspection. We saw that this increased people's risks. However, there had been no actions taken to address this concern in practice.

Some staff told us that they did not receive regular supervision. We asked the home manager at the start of the inspection if there were any performance concerns with care staff at the home and they told us there were not. However, senior nurses told us of concerns over carer's knowledge and competency, which they were unable to oversee due to workload, and that charts were filled in retrospectively because staff felt they did not have sufficient staffing to meet people's dependency needs in a timely way. When we discussed with the home manager issues of illegible clinical records, they told of us that they were aware of the situation and managing it.

Because of this information we asked some staff if we could review their supervision records and we saw that in some supervisions concerns about individual staff performance had been identified but no action plans were in place. There was no set timeframe for staff to improve and we found that supervision records were not always legible. Consequently, we could not see how the service was assuring that staff had the skills to provide care that was safe, effective, caring, and responsive to people's needs.

The home manager told us that staff morale was good and that they were proud of their team. Staff told us that the home manager was very approachable and hands on. We saw that the home manager knew people at the service and their loved ones very well. Staff told us that they felt things had got better at the service since the initial inadequate rating. However, morale was not always good. Staff told us that they did their best in providing care, but the level of dependency of people needs was not considered when looking at staffing. This included assessments of people requiring admission. Senior qualified nurses felt that they were stretched to try to complete all the tasks of the registered nurse on shift and that this took its toll.

Staff meeting minutes meetings only demonstrated a time for managers to feedback to staff and demonstrated lack of opportunity for staff to discuss concerns that they might have. Therefore the service did not use processes that might have identified the issues we found to safeguard people at the service.

This is a breach of Regulation 17 (1) (2) (b) (c) (e) (f) HSCA 2008 (Regulated Activities) Regulations 2014, Good Governance.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not receive care that was person centred and promoted independence and mental well being. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>Staff did not keep contemporaneous records of fluids and nutrition provided to people at risk of malnutrition and dehydration. People in bedrooms did not always have physical access to drinks left for them. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Managerial systems in place to quality assure the service were not effective. When issues had been raised through internal audits and complaints these had not been addressed and action plans were not measurable. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The service did not use dependency banding to ascertain level of staff needed to care for people at the service. People's needs were not met in a timely safe manor. |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | Systems, processes and risk assessments in place to monitor and manager people's safety and well being did not quality assure that they were care for safely. |

**The enforcement action we took:**

We suspended admissions to the service and required the service to submit to the Care Quality Commission weekly action plans, and information about people's clinical risks and how they were meeting these people's care.