Greenswan Consultants Limited

Pinelodge Care Home

Inspection report

Graveley Road
Stevenage
Hertfordshire
SG1 4YS

Tel: 01438721417

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on 18 and 25 September 2018 and was unannounced. At their last inspection on 28 March 2017, they were found to be meeting the standards we inspected. At this inspection we found that there were some areas that required improvement and they were not meeting all the standards.

Pinelodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates up to 140 people in an adapted building. At the time of the inspection there were 120 people living there.

The service had a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

There were systems in place to monitor the quality of the home. However, they had not identified the areas of concern that we found on inspection. However, people and staff were positive about the running of the home and the management team.

Most people were supported in a safe way. However, some assessments and processes did not always promote this. We also found that although there were systems in place to monitor medicines management, medicines were not consistently managed safely.

Staff knew how report any risks to people's safety. However, fire safety needed to be reviewed to ensure staff knowledge was robust and infection control was not always promoted.

Feedback about staffing was mixed. Staff received regular updates to their training and were recruited safely.

Most people were supported in accordance with the principles of the Mental Capacity Act 2005. People gave mixed views about the food and the mealtime experience needed to be improved. The environment had some areas that needed to be addressed.

People told us most staff were kind, however some people told us other staff were not as kind. The service needed to ensure people's dignity was always promoted and that people's involvement needed to be consistently reflected in the planning of their care. Confidentiality was promoted with records held securely.

People did not receive care in a person-centred way and there were mixed views about the activities provided. There was a complaint's process which people and their relatives knew how to use. However, not all issues or concerns were shared with the registered manager by staff.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Medicines were not always managed safely.

Feedback about staffing was mixed.

Infection control was not always promoted.

Most people were supported in a safe way. However, some assessments and processes did not always promote this.

Fire safety needed to be reviewed to ensure staff knowledge was robust.

Staff knew how to report any risks to people's safety.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not effective.

People were supported by staff who had updates to their training.

Most people were supported in accordance with the principles of the Mental Capacity Act 2005.

People gave mixed views about the food and the mealtime experience needed to be improved.

There were some areas of the environment that needed to be addressed.

People had access to health care professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us most staff were kind, however some people told

us other staff were not as kind.

The service needed to ensure people's dignity was always promoted.

People's involvement needed to be consistently reflected in the planning of their care.

Confidentiality was promoted.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not receive care in a person-centred way.

There were mixed views about the activities provided.

There was a complaint's process which people and their relatives knew how to use. However, not all issues or concerns were shared with the registered manager by staff.

Is the service well-led?

Inadequate

The service was not well led.

There were systems in place to monitor the quality of the home. However, they had not identified the areas of concern that we found on inspection.

People and staff were positive about the running of the home and the management team.

Pinelodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection was brought forward due to an increase in information we had received about the service relating to risk.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We did not request a provider information return (PIR) at this inspection. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.
The inspection was unannounced and carried out by three inspectors and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with 10 people who used the service, eight relatives, 10 staff members, two deputy managers, the registered manager and the provider. We received information from service commissioners and health and social care professionals. We viewed information relating to eight people's care and support. We also reviewed records relating to the management of the service.

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

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed in accordance with the prescriber's instructions. We saw that there was a staff signature list and there were weekly checks of boxed medicines. However, although most medicines we counted were accurate, we found that some quantities of stock did not tally with records of medicines received into the home and administered. For example, there was one more tablet than expected which meant people may have not received doses of medicines. We spoke with the nurse responsible and they told us that they had administered the medicines but not yet signed for them. On arrival we found that a clinical room was unlocked and unsupervised. Inside this room was also an unlocked trolley. This gave access to the medicines to people who lived in the home, staff and visitors. We also found that people did not have protocols for medicines that may be given on an as needed basis.

People living at the service had bedrails on their beds. In most cases, were bedrails are in place, protective padded bumpers are used to prevent injury or entrapment. However, we saw examples where people only had one bumper or no bumpers fitted. We reviewed the bedrails risk assessments and noted that they did not record if bumpers were to be used. We asked a member of the management team if it was an expectation that bumpers should be in place for bedrails and they told us, "Yes it is, for safety." They went into a room for a person we had identified with one bumper in place and found the second bumper on top of the wardrobe. However, this issue had not been identified by staff during their care delivery, checks or walk rounds. On the second day of inspection we found that the same person only had one bumper in place again.

The service carried out weekly checks on the fire alarm system and had this, along with extinguishers, serviced regularly. Most staff received fire training annually. However, we noted that the service had not had a recent fire risk assessment completed by a competent person. The old risk assessment completed a number of years ago had been reviewed by the deputy manager who was the fire marshall. In addition, we found that peoples personal emergency evacuation plans (PEEPs) were sparse and staff did not know how people should be evacuated in the event of a fire. We asked how they would evacuate a person who was bedbound if there was a fire and they told us that they would hoist them. There had been a fire drill in March 2017 and then the alarm had been activated in February 2018 and this had formed as a drill. The policy at the home was for two fire drills each year. However only one had happened in 2017. We asked the management team how they ensured that all staff attended at least one drill per year and they told us that they discussed the process as part of their annual training. However, as staff were not clear on what to do and what each PEEPs contained, this was not effective. We noted that members of the management team had recently attended fire training provided by the fire service that had informed them of the importance of having these checks in place but the appropriate action had not been taken in response to this training. Following the inspection, the registered manager sent us information stating that the provider had arranged for a competent person to complete a fire risk assessment at the service the following month and the regular fire drills had commenced.

Systems were in place to help ensure effective infection control. However, we noted that staff did not always follow these systems. For example, we observed on two occasions staff carrying soiled laundry down

corridors without using bags and touching door handles and keypads with gloves that they had carried the laundry with. We also noted that areas within the home were dirty. Some of which had been there for some time. One relative said, "The walls and doors have fingerprints and marks. When it's sunny you can see more. There were cobwebs in the family room last week and moths in the light." Another relative took us to their relative's room to show us the standard of cleaning. We noted that there was food in an unused chair, food spillages on the bed and wall and the carpet needed cleaning. The feet to the bed and pump for the mattress were also dirty. The registered manager had told us that they were experiencing difficulties recruiting domestic staff during a recent staff changeover. We also noted on one occasion that the cleaning trolley was left unattended. There were no staff near the trolley which had cleaning products such as toilet descaler on it, which was next to a drinking cup. The service had a risk assessment for cleaning products stating that they must be stored securely and not left unattended due to the risk of being ingested as the service supports people living with dementia. Following the inspection, the registered manager told us that the provider had obtained quotes from professional cleaning companies to deep clean the home.

The concerns in regards to safety were across multiple areas of the home and therefore this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us they felt safe. One person said, "I feel as safe as anything." Relatives also told us people were safe. When asked if they felt people were safe, one relative said, "Yes. The care [person] gets, I can't fault. I've never had an issue with feeling comfortable when I go home." However one person told us, "There's one at night in particular. She shouts at me about everything. If I try to tell her something, she's furious. She has to turn me over and she hurts me." The person explained that it was the way this staff member turned them that hurt. They added, "I've not complained. If I did she would be awkward and so would her mates. They know your complaint is true but they stick together." The person would not give us any indication of who the staff member was. We raised this with the management team who told us that they were aware of these concerns and on investigation and ongoing monitoring, supervision and training was in progress. The appropriate safeguarding investigation had commenced.
Staff knew what abuse looked like and were aware of how to report concerns. There was information displayed around the home about how to report concerns which helped to raise awareness. We also noted the safeguarding and whistleblowing were a regular agenda item on the staff monthly memos.
People had their individual risks assessed and staff were knowledgeable about risks associated with people`s daily living. They were able to tell us names of people who were at risk of falls, at risk of developing pressure ulcers, behaviour that challenged and at risk of malnutrition. However, we found that risk assessments were not always completed appropriately to offer guidance to staff how to mitigate the risks. For example, for people who had falls staff completed a fall risk assessment tool to establish how high the risk was. We found that some people were high risk of falls, however they had no detailed risk assessments or care plans developed to detail what measures and actions staff had to take to mitigate the risk further in order to reduce and prevent future falls. However, we also noted when reviewing the accident analysis that falls had reduced and there were no obvious themes and trends.

People who were at risk of developing pressure ulcers had risk management plans in place to support staff in understanding how to mitigate these risks. For example, people had appropriate pressure mattresses in place and staff regularly checked if these were set at the right setting. In addition staff regularly repositioned people who were not able to change their position in bed. We found that this was effective in preventing people to develop pressure ulcers and in healing those for people who moved into the home already with a pressure ulcer. The number of pressure ulcers in the home and their progress was reviewed by the registered manager monthly.

Accidents and incidents were recorded and this was added onto a monthly analysis for the registered

manager which helped them to identify themes and trends. This system also checked that all remedial actions had been taken. We noted that where unexplained bruises were found, the appropriate action was taken to ascertain how they occurred. A record for one person noted that at times during personal care they may hit out with their arms causing them to knock themselves. We saw from records that the member of the management team who completed the investigations noted that they were reminding staff to be more careful when supporting people. We noted that there had been a graze to a person's ankle during being transferred with a wheelchair. We observed staff rushing at times, and one person being pushed quite fast in a recliner chair down the corridor. This was a factor that may increase the risk of bruising or skin tears as staff may not always take their time. This was an area that needed to be monitored and required improvement.

People and their relatives told us that there were not always enough staff to meet their needs. One person told us, "If I ring the bell, it's sometimes a few minutes, sometimes longer. (There are) so many people and not enough carers." Another person told us, "Staffing normally means I have to wait. Weekends are worse."

Relatives gave mixed views about staffing. One relative told us, "Sometimes it's difficult to find somebody – fifteen minutes maybe (to find someone).. I feel confident in the staff. Weekends are possibly worse. They're busy. They're more than happy when we do need somebody." Another relative told us, "On a 1pm visit I found [person] in bed, lying flat and really shaking. [Person] was shouting 'help, help'. Nothing was in reach. A staff member apologised the next day and said it was shortage of staff." However, a third relative said, "There are quite enough staff around. (I have) no issues with staff at all."

During the inspection we noted that people's needs were mostly met in a timely manner and call bells were answered promptly. However, we also noted that staff did not have time to spend with people and care was task led. Staff told us that there were not always enough staff to meet people's needs. They told us when the home was fully staffed they managed but during periods where the home was short staffed, it was a challenge. One staff member told us, "Today is a good day." Another staff member described the shifts as, "A mad rush, it depends on the staff who are working, regular staff ok but not if not regular." We asked the registered manager to provide us with the number of shifts that have worked short in the past month. We saw that there had been 25 shifts out of 260 shifts across the five units that had been short by one staff member. We also saw that on other days, shifts were staffed with a higher number to anticipate any staff sickness. The service assessed the dependency of people and calculated this into the number of staff they needed. However, we noted that many people had behaviour that challenged and several people needed two staff to support them. This meant there were several times through the day where staff were busy and people sat in the lounge with no staff visible and people in their rooms did not receive any interaction or stimulation. We noted however that the analysis in the home indicated that incidents between people had reduced, and also falls and the number of pressure ulcers had reduced. This indicated that ordinarily people had their needs met. Albeit on a task basis rather than person centred basis. The registered manager told us that the previous month had been challenging in regards to staffing and they were recruiting constantly. The management and deployment of staff was an area that needed to be reviewed and required improvement to ensure people's needs were consistently met in a timely fashion.

Safe and effective recruitment practices were followed to help make sure that all staff were suitable to support people who may be vulnerable. All pre-employment checks were completed to help ensure staff were fit for the role. This included written references, proof of identity and qualifications and criminal record checks.

Lessons learned were shared by the registered manager to all staff through a monthly memo. This included information about any safeguarding updates, complaints, incidents or changes or expectations of practice.

Requires Improvement

Is the service effective?

Our findings

People and their relatives gave mixed views about the food. One person said, "(The food) is good for people who eat anything. There's a lot of things I don't like. I had better choice with meals on wheels. There's never anything much for tea. My (relative) says I should tell them what I want. The soup is nice, and cheese and biscuits. The carer who's just gone out (left the room) makes a lovely toast or fried bread and eggs. Some will do a lot more for you than others." They went on to say, "I had scrambled eggs and toast once. It was lovely. Then another one, she brought burnt toast and watery eggs. I told her and she just laughed." Another person said, "The food is well cooked, it's just not the food I like." They went on to tell us that they were offered a jacket potato or salad as an alternative these were the only choices. A third person said, "The food is good." A relative told us, "The food is not really suitable. It's too hard or foreign. Sometimes there are two foreign foods so no choice. [Person] has to have a jacket potato and she's not really keen on that. There's not enough veg. Lots of peppers and herbs; people don't always like it." Another relative said, "[Person] can't say (verbalise choice). What if I'm not here? Old fashioned food is needed. Residents don't know what a wrap is. The bread at tea time is hard. One day [person] was in bed and there was food on the side. She never eats in bed." We asked a member of the management team if they ever completed a food survey to ascertain what types of food people enjoyed. They said, "We haven't done that for a long time."

We found that the mealtime experience varied across the home. We saw that at breakfast people had a variety of choices including cereals and cooked breakfast. We noted some people had their food in a finger food style to support them to eat independently. At lunchtime there was a choice of two meals. Staff told us that if someone didn't like the choices then an omelette or jacket potato could be offered, we noted one person had a salad. However, on one unit we also heard one person say they didn't like spaghetti bolognaise. When staff asked what they wanted instead, the person, who was living with dementia, didn't speak so they gave them bolognaise. There was garlic bread as a side dish, however, this wasn't offered to everyone. Extra thought about cheese for on top of the pasta as it would be offered in a restaurant or condiments were not considered by staff. We asked staff about condiments and they told us they were in the cupboard. One staff member told us, "They can ask if they want it." When asked about people living on the unit who predominantly all lived with dementia, should be offered the condiments, they told us, "Well I know we should really." The mealtime experience was rushed and was not a highlight of the day. People were not given visual choices to help them decide on what they wanted and menus were handwritten on whiteboards rather than being accessible to people.

On two of the five units we found that staff rushed around and in many cases, spoke over people's heads and in many cases, didn't engage in conversation if they were supporting people to eat. One staff offered to speak with us during assisting a person to eat stating that they were, "Only doing this." We declined and suggested once they had finished supporting the person with their meal.

One person was wondering around using their pudding spoon to eat other people's left overs but no-one intervened. A more senior staff member came in and no-one knew what the person had eaten. We noted that people were not offered plate guards resulting in one person pushing their food from their plate, into their lap, where they then ate it from with a spoon. A staff member came over and wiped the person's hands

but didn't acknowledge the issue with them managing to eat. A relative told us, "There doesn't seem to be a system for feeding. I feed [person] when I'm here but I can't be here every day. I have seen a care plan but there is nothing in it about helping [person] to eat. [Person] puts her hand in (the food) and all over her hair. How bad do you have to be to get the help? The other day [person] was in bed and there was chocolate mousse all over the bed. The staff say, 'she's fine'. Other residents say she doesn't eat much when I'm not here."

When we raised any concerns about people needing support with eating or drinking, the response from some staff was that they didn't like staff to interfere. However, there was no assessment in regards to their best interests and there was no plan to support these issues. People told us that they didn't always get a choice and relatives told us that they were concerned that on days they didn't visit, choices were not offered. We discussed the mealtime experience with the management and following the inspection they showed us a tool for observing mealtimes and to guide staff. However, this was an area that required improvement.

Drinks were available on the units. We observed some staff supporting people to drink. Some people had their fluids recorded but the quantity was not always tallied with a target quantity that people should try to consume in a 24-hour period. We asked staff about one person in particular who had lost a significant amount of weight. They told us that there were not on a food and fluid record chart. They said, "What is the point in recording it if we know [person] is not eating?" They had noted that the person liked the supplement drinks now provided by the GP, however, as the person enjoyed these and little else, the staff had not considered getting this increased from one bottle to two or three to support their nutrition.

The registered manager monitored people's weight as part of their clinical checks. This helped them identify any action that was needed. However, staff on the units took the responsibility to contact health professionals and initiate plans if they were needed. The kitchen staff told us that they routinely fortified foods to help give people sufficient calorific intake to boost their nutrition.

However, due to the widespread concerns in relation to the mealtime experience, this was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People and their relatives gave mixed views about staff skills and knowledge. One person said, "Some do, some don't (seem well trained). Some are very poor and don't listen if you ask them to do it a certain way. It's upsetting." One relative said, "Yes, they are (well trained). There is ongoing training and everything for them."

Staff received training in mandatory areas such as safeguarding from abuse, moving and handling, dementia care and first aid. We found that most was up to date. However, following the inspection, the registered manager informed us that some staff would be having their competency reassessed to identify any training needs as a result of our feedback.

Staff told us that they received an induction training when they started working for the service. They told us they felt that the induction training was effective in helping them understand their role. One staff member said, "Training is done- dementia, manual handling. Now refreshers." Another staff member said, "Refresher training is done yearly and last one infection control. Fire training not given but told what to do." We asked the registered manager about this who told us that the training was a walk round with scenarios ensuring staff were familiar with the building and processes. The staff member told us that they had worked in care before but they still had an induction. New staff worked alongside experienced staff members when they first started as a buddy system to help them get to know people and the building.

Staff told us they felt supported by the management team and we saw that supervisions were completed regularly. One staff member said, "Regular supervisions. The nurses are very supportive. Registered manager very approachable and we can talk to them any time." We saw that the supervision form had recently been updated to better capture the conversation, test knowledge, support with issues and plan personal development.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The management team demonstrated an understanding of when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. They knew what steps needed to be followed to protect people's best interests and how to ensure that any restrictions placed on a person's liberty was lawful and they had their human rights to freedom protected. However, documentation was not consistently in place for all relevant aspects of people's lives. For example, in one instance where a person had bedrails, it was documented that they were put in place not to prevent the person falling from bed but to stop the person getting up in case they suffered a fall. There was no best interest's decision documented or reference to alternative methods made. We discussed this with the management team that if the correct process was not followed how can they be sure it is the person's best interest and not unlawfully restricting them. The management team were aware of the required process and told us that the staff member completing the process had worded it incorrectly. They assured us that this would be amended and any other plans completed in the same way would be reviewed. This was an area that required improvement.

People gave mixed views about the choices they had. This was mainly in relation to food choices and what time they wished to receive care. One person told us, "Some days they come and ask me (about menu choices) other days they don't." People were asked for their consent to care and staff explained what was happening in most cases when supporting them.

Staff involved health care professionals in people`s care when there was a need for it. One relative told us, "The chiropodist comes round and the doctor. The nurses here work in the hospital as well. They are fully trained." Staff told us about involvement from GP, dieticians, chiropodists and opticians. On the day of the inspection we saw people were visited by the chiropodist and the hairdresser.

The home was designed in a way so that people could move around easily, whether this is independently or with the use of mobility aids. Equipment was available in bedrooms and bathrooms to enable people to be independent where possible. There was an appropriate supply of mobile equipment, such as hoists or commodes, to ensure there was not a delay for people waiting for assistance. However, a relative told us, "There's been a health and safety issue. The drawers (in the person's room) were hanging off. They've replaced them now but it took about two weeks. It was dangerous." We were told that the service was short of one of their maintenance people and the one in post was covering the service when they usually had two.

There were call bell points available in all rooms in case a person needed assistance. There were lounges with sufficient seating on each floor and plenty of dining space so people could eat together if they wished. Bedrooms were personalised in most cases and there was also an accessible garden. There had been thought to some areas of decoration, this included a sports wall and a wedding wall which had photos of

people and staff on their wedding day. There were also some themed rooms, this included a café, a pub, a sensory room and a music room. We did not see these in use on the day of inspection. The café and pub were both locked so people couldn't access them freely. Some staff told us that they get used when activities staff host in them. We noted on previous inspections we hadn't seen these rooms in use either. The home was in need of redecoration in some areas. Many walls had scuffs and chips from them. The registered manager told us that there were plans for all the flooring to be replaced and the provider was arranging this with a contractor that they used. We noted that the torn flooring outside the toilet was identified in January 2018 by the audit process and this was yet to be completed. We also found that corridor area of the house, not regularly used by people who used the service, had some large cracks in the walls. We asked the provider if they had had this checked. They told us that it was checked two years ago and the cracks just needed to be filled. We asked for the report from the person who checked the cracks in the walls and the provider told us they would arrange for a competent person to come and ensure it was safe. We also found one shower room that had significant hazardous damage to the ceiling indicating that there was a leak. The management team had not been made aware of this by staff. The provider told us that this would be repaired by the end of the week. These were areas that required improvement.

Requires Improvement

Is the service caring?

Our findings

People told us that most staff were kind. One person told us, "That was something that struck me when I first arrived, how nice and polite all the staff were." Another person said, "They are all nice." However, people also said that some staff can be less friendly. One person said, "Some (staff) are very good. Others are not if you don't do what they want, and I'm not like that."

Most staff treated people with dignity. They addressed people using their preferred names and we found that staff knew people well. Staff knocked on bedroom doors and greeted people when they went in. Bedroom doors were closed when staff provided personal care to people and their preferences in relation to an open and closed door was reflected in care plans. However, we also found that people's dignity was not always promoted. For example, one person was in the lounge when we arrived and clearly was in need of personal care due to being incontinent of faeces. When we walked round the corridor we found their room also soiled with the door open. Other people were unshaved and another person walked to lounge by a member of staff with their bottom half dressed but they had a pyjama top on, unbrushed hair and a dirty mouth. We also found that some people did have dirty finger nails and some had not had their hands cleaned before eating their meals. This was an area that required improvement.

There was little evidence in how people influenced and participated in their care delivery. Some people signed their care plans to agree for their records, however there were no records to indicate they reviewed their care plans. We saw that some people`s relatives signed care plans and also had meetings with staff to discuss the content of the care plans. We noted that some reviews included relative's comments. People told us that they were not always included in reviewing of their care. One person told us, "They speak to my [relative]." We asked if that was their choice, they said, "Well no but [relative] wants to know everything and is involved so they don't ask me." We also noted in one review? that a person and a relative had raised concerns about how some staff treated them and that they were not talked to. The reviewer's response was noted as saying, 'Suggested they may be better in another care home.' This response did not promote sharing concerns or making requests but only offered what could be perceived as a veiled threat. We raised this with the registered manager and deputy managers who were surprised at the content and told us they would address it as they would expect the response to offer ways to help with their concerns and offer an apology.

Therefore due to the lack of consideration to some care needs and person centred care, this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff were observed to be friendly, courteous and smiling when communicating with people during the inspection. We heard staff when supporting people who were anxious and shouting during personal care in a kind and calm way, offering reassurance and explaining what they were doing. Long serving staff had developed relationships with people. We were told that some people had attended the wedding reception of a staff member. There had been a change in some staff in recent times and this had affected people as they had missed seeing staff that they knew well.

There was a regular church service at the home and people could chose to attend. However, for people whose religious beliefs or faith could potentially influence the care and treatment they receive this was not incorporated in their care plans.

People were encouraged to maintain relationships with family, friends and partners. Visitors were encouraged and invited to events and staff knew about who was important to people. One relative told us that staff had been key in arranging for them to enjoy valentines and their anniversary together, arranging for them to go to dinner. Another relative told us that they can have a bed put in their spouse's room so that they can spend Christmas together.

People's records were stored in cupboards in locked offices in order to promote confidentiality for people who used the service.

Requires Improvement

Is the service responsive?

Our findings

People's basic care needs were met in most cases. One person told us, "There are two nice girls at night. When they're not on I don't know who's on. I get anybody, not the same. I'm not as happy as I was. All the good ones are going. I've nothing against foreign people but there's one who doesn't understand. If I want the commode, I have to point." Relatives gave mixed views. One relative told us, "They don't like to mobilise [person]. [Person] still has mobility. [They] can walk from the lounge to [their] room but they won't do it anymore. [Person] walked with [staff member] the other day. They don't want to (walk with [person]). [They are] left in her wheelchair or a chair." However, another relative said, "The home is wonderful. The cream of the crop. They help me too (as well as resident). Everyone knows your name. I couldn't wish for a better place." They went on to say, "They manage to keep [person] clean and fresh, clean clothes every day and if there's a smell they come and check [them] and change [them]."

Care was not always person centred. People told us that they were not able to have a bath or shower when they wanted. One person said, "They spoil me. I have a [staff member of the opposite gender] who showers me and washes my hair." We checked that this arrangement was welcomed by the person and it was. Another person told us, "The other day I needed to go to the toilet and I waited over two hours because they told me they were doing breakfast. In the end it made more work for them as I had an accident." Another person said, "They change my pad at 2am ish. I don't think they would do it at a different time if I asked. The difficulty is getting someone to do it in the night. They say there are not enough staff. A fortnight ago, I waited 2 hours and 54 minutes after I asked them to do it. It's supposed to be every four hours." A staff member told us that they based their routine on tasks that needed to be completed first, not on preferences. For example, people who need to be up for breakfast receive care first and those who stay in their rooms get care afterwards.

Relatives gave mixed views about the standards of care. One relative spoke about experience of a different care home and felt this was much better. However, some relatives did also voice concerns about the standard of care when they were not visiting. They told us they were not sure that everything happened as it should in their absence. One relative said, "Sometimes they don't give [person] enough clothes and [they're] cold. [Person] never has a vest or socks. We have asked about this but [they] still had no socks. [Person] never liked to be cold." This person was brought into the room by a staff member. The relative said "That's not [their] dressing gown. [They're] wearing someone else's dressing gown." The staff member told them they would change it.

Care plans varied in content, depending on who had completed them. Some had detail enabling staff to provide care in the appropriate way. However, others had the need assessed but did not explain how to meet the need. For example, a plan would state that a person needed assistance with mobility but not always the process to be followed to support them. Some plans were on old records, dating back three years, which meant a staff member would need to be read three years of monthly evaluations to check for the appropriate level of support that was needed. The registered manager had identified this as an issue but it was yet to be addressed. This was an area that required improvement.

Therefore, due to the lack of consistent person-centred care this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People gave us mixed views about the activities available. One person told us, "I don't have enough to do." Another person who spent time in their bed told us, "No they don't come in and do anything with me, they are too busy." A third person, who spent their time in their room, told us, "Once someone came in and played cards." A relative told us, "Activities are just half an hour here and there. The rest of the time, nothing, (Resident) over there can play the organ but it's been moved downstairs. There are four down there. Residents are asleep. If you talk to them 1:1 they wake up and chat. It's quiet as a mouse in here; not enough activity. There should be music, exercises." However, another relative said, "They will often take [person] to activities. They encourage [them]. [Person] was in the cinema room yesterday. [Person] enjoys the interaction." We noted that people were asked about their interests and hobbies but we could not see how these were incorporated into the scheduling for activities, outings and events. For people who spent most or all of their time in bed, the variety of activities was limited. There was limited time spent chatting to people, there was not much else offered to people in their beds. This was an area that required further development to ensure people received sufficient stimulation to prevent isolation and promote wellbeing.

Activities and events in the home included Art and crafts, games, quizzes, flower arranging, outside entertainers and singalongs. There had been some outings arranged that people told us they enjoyed. Staff told us that the café was used for coffee mornings on a Friday and sometimes people were taken to the 'pub' room for lunch. There was a music room and sensory room also. However, these were not used on the day of inspection. People sat in the lounge in silence. After a while a staff member came in, put a film on without discussing it with people in the room and then left. The film started with three minutes of naked people dancing around. There had been no consideration if people wanted to see this or if young visitors came into the home, which they later did. However, activities were an area that required improvement.

The service supported people at the end of their life. People had their wishes documented in their care plans to guide staff on how to support people when they reached the end of their life. The home regularly supported people at the end of their life.

There were complaints documented. We noted that these had been investigated and responded to. However, some relatives said that they did not always feel that the issue had been resolved. Relatives had raised issues with staff on units and the issue continued. For example, about the cleanliness of a bedroom. We found that not all issues raised with unit staff made its way to the registered manager. We discussed this with the registered manager who told us that in some cases the staff had felt they had addressed the concerns and a formal complaint had not been made so they did not escalate it. Without being informed of these issues, resolved or not, themes and trend in complaints cannot be monitored and the registered manager cannot satisfy themselves that actions taken by unit staff were sufficient. This was an area that required improvement.

Inadequate

Is the service well-led?

Our findings

There were ineffective quality assurance systems in place to identify and address shortfalls in the home. These included internal audits and checks reviewing medicines, care plans and the environment. We found these audits, checks and visits identified where some issues needed action and the action plans were effective in resolving the issues. By using these audits and sharing the findings and lessons learned with the staff team. However, we found issues on inspection that had not been identified during the quality checks.

This was in relation to concerns raised, care planning, the mealtime experience, standards of care and person-centred care, fire safety, medicines and infection control. When discussing these issues with the registered manager they told us that they were aware of some of these concerns and had added some remedial actions to the service improvement plan. For example, environmental refurbishment and updates to care plans. There had recently been a change of staff in the home resulting in a reduced overview and monitoring of the units and standards of the service. The registered manager informed us following the inspection of action taken in response to our feedback to address the shortfalls. However, these areas were not identified or addressed prior to us raising them through the inspection process.

The provider told us that the change in staff had an adverse effect and they service was still trying to recover from this. However, no additional steps had been taken by the provider to ensure the registered manager was supported to fulfil their role and address the shortfalls. We also noted that the concerns we found during the course of the inspection were that of bad habits and a lack of compassion by staff who were supporting people which appeared to be something that had not only occurred in recent weeks which indicated a lack of oversight and guidance for a longer period of time.

The systems in place to monitor the quality of the service needed to be addressed to ensure that they consistently identified areas that needed to be improved. Therefore, due to the issues found throughout the service, this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People and their relatives were positive about the registered manager. One person told us, "[Deputy manager] is who I would speak with if I was worried." They went on to say that they were confident that they would be listened to and the appropriate action would be taken. One relative said, "The manager is very good." Another relative told us, "[Registered manager], She's lovely, joins in, one of the girls. Yes, it's (well managed); great. [Provider] is good too. He comes to events and always speaks. There are residents' meetings every 3 months and he comes to those. Everything you ask for, it's done." Another relative said, "The manager is (named). I see her quite often. The home is well managed. I've not seen any emergency situations."

Staff told us they felt that the registered manager was accessible and supportive. One staff member told us, "They are willing to listen to our suggestions and anything we need they will either supply or we fund raise for example for our I-pad and the jukebox in the pub." Another staff member said, "[Registered manager] is very approachable and I do go and speak to her." Another staff member said, "[Registered manager] and

[deputy manager] are very approachable and they listen." Staff told us that morale was low and the main frustration was not knowing what unit they were working on. The registered manager moved staff between units for skill mix, especially as there had been a staff changeover. One staff member said, "No complaints, just staffing but they are advertising."

There were staff meetings were the registered manager set out expectations and practice to be put into place. Staff memos were issued monthly to ensure that all staff received information important to them for updates to practice and feedback from audits, safeguarding concerns or anything else they needed to be aware of. Staff told us that they felt they were kept informed and were aware of what they needed to be doing. There was a staff member of the month system in place where staff members were given recognition if their performance meant they earned it.

The service worked in partnership with other agencies to help ensure people received the appropriate support. We noted that there was contact with the local authority who had a contract with the service to provide permanent care beds. They last carried out a monitoring visit in May 2018 when they followed up on the outstanding actions. The registered manager had incorporated their findings in their service improvement plan and had been working through completing them.
The provider uses an independent agency to complete an annual survey. This was due to be issued for the current year.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The registered manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that people received consistent person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that people's safety and welfare was consistently promoted.

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 did not always have the nutritional needs met fully and the mealtime experience was not a positive experience.

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 The systems in place to identify and address shortfalls in the service were not effective.