Mr & Mrs A Ollivier

Harecombe Manor Nursing Home

Inspection report

Harecombe Manor
South View Road
Crowborough
East Sussex
TN6 1HG
Tel: 01892 652114
Website: www.harecombemanor.co.uk

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Ratings

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

Overall summary

This inspection took place on 7 and 9 September 2015. It was unannounced. There were 36 people living at Harecombe Manor Nursing Home when we inspected. People cared for were all older people who needed nursing care and were living with a range of care and treatment needs, including stroke, heart conditions, breathing difficulties, diabetes and arthritis. Many people needed support with all of their personal care, eating and drinking and mobility needs. Some of the people were also living with dementia. The registered manager reported they provided end of life care at times. No one was receiving end of life care when we inspected.

Harecombe Manor Nursing Home is a large manor house which has been extended. People's bedrooms were provided over two floors, with a passenger lift

Summary of findings

in-between. There were a sitting and dining room on the ground floor, with an additional sitting room on the lower ground floor. Support facilities such as the laundry and training room were also provided on the lower ground floor. There was a wheelchair accessible terrace overlooking the extensive garden areas. Harecombe Manor Nursing Home was close to the middle of Crowborough. The provider for the service was Mr and Mrs Ollivier.

Harecombe Manor Nursing Home had a long standing registered manager. 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.

Harecombe Manor Nursing Home was last inspected on 2 and 4 December 2014. They were rated as inadequate at that inspection. The Care Quality Commission (CQC) issued a Warning Notice after the inspection in respect of assessing and monitoring of the quality of the services. The provider sent us an action plan which detailed when different areas would be addressed. This stated all matters would be addressed by 31 May 2015.

We found the provider had not met the Warning Notice or addressed most of their action plan by their due dates.

As at the last inspection, systems to regularly assess and monitor the quality of the service were not effective and failed to identify and manage certain risks to the health, welfare and safety of people. This included ensuring they had met the areas they needed to address identified in the previous report and ensuring they followed their own policies and procedures.

As at the last inspection we continued to find people did not have a full assessment of all their needs carried out and did not have their care planned and delivered in such as way so as to meet their individual needs. This included systems for prevention of pressure damage and risk of injury to people from falls. As at the last inspection, people were not supported with engagement by the provision of meaningful recreational activities, which met their preferences.

People were still not protected against the risks associated with unsafe management of medicines. This was particularly in relation to 'as required' (PRN) medication and appropriate support for people who wanted to take their medicines independently.

People were still not protected from the risks of inadequate nutrition and hydration. People who needed assistance did not receive the support they needed to drink sufficient amounts. Records relating to amount of diet people ate were not adequate to show people had received the nutrition they needed.

The provider continued not to have suitable arrangements for ensuring the consent of people. This was particularly where people remained in bed all the time. Relevant referrals had not been made to external bodies to ensure people were not deprived of their liberties. Referrals had also not been made to relevant professionals to develop such people's care plans.

At this inspection both people and staff told us about lack of staff availability, particularly a slow response time to call bells. People also did not have support from staff for extended periods of time when they were in the sitting room, because of staff availability. The provider had not done an analysis, such as a dependency assessment or assessment of response times when call bells were used, to assess if the number of staff on duty were enough to meet people's needs.

We received mixed comments from people about how they raised issues and were consulted about the service they received. Several people told us about issues which had concerned them. Records of matters raised formally were documented but informal issues, such as those raised with us during the inspection were not documented, so the provider was not made aware of them to ensure they took relevant action.

The provider had taken action in some areas. At the last inspection, we identified systems to assess the risk of infection were not effective and appropriate standards of cleanliness and hygiene were not maintained. At this inspection, the provider had ensured this had been addressed and all areas were clean and necessary equipment to reduce risk of infection was available.

At the last inspection, we identified issues relating to a range of areas, including ensuring safe bed rails. This had been addressed and all bed rails were being safely used

Summary of findings

in accordance with guidelines. New hoists to support people with their mobility had also been provided. Action was being taken to ensure the safety of windows and of fire doors.

At the last inspection, we identified recruitment procedures were not satisfactory. The one member of staff employed since the last inspection had relevant documents on their file to demonstrate their suitability to work with people.

The provider had developed a training plan and staff had been trained in relevant areas such as fire safety. Plans were in place to ensure staff were trained in other key areas such as the Mental Capacity Act 2005. Staff showed an awareness of actions they needed to take to ensure people were safeguarded from risk of abuse. Systems for supporting staff by supervising them in their roles had commenced.

Staff supported people in a caring way, including during medicines rounds. People said they could choose, for example what clothes they wore. Staff, including an agency care worker, knew the individual needs of the people they were caring for. Visitors said they could come and go as they wanted to.

People spoke positively about the meals. The lunchtime meal was given to people in attractive surroundings and the meal smelt appetising.

Staff said they could raise issues with the management of the home. They reported positively on the philosophy of care to ensure people "Came first."

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

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

CQC are taking enforcement action to ensure that Mr and Mrs Ollivier provide safe and effective care.

Summary of findings

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 always safe

Sufficient staff were not always deployed to meet people's needs.

Assessments for risk were not always accurate and actions to reduce risk to people ensured.

Systems for management of medicines did not ensure risk to people was always reduced.

Staff were recruited effectively and people were safeguarded by the provider's systems to prevent risk of abuse.

Appropriate action had taken place to ensure a hygienic home and reduce risk of cross-infection.

Is the service effective?

Inadequate

The service was not always effective

Where people lacked capacity, effective processes did not take place to ensure they were not deprived of their liberties.

Arrangements to ensure relevant assessments from external professionals did not take place in all necessary areas.

The provider's systems did not ensure people were protected from hydration risk.

Systems were being progressed to support staff by a training and supervision programme.

Is the service caring?

Requires improvement

The service was not always caring

The provider had not ensured people were responded to promptly when they needed to use the toilet. Staff did not always have time to engage with people.

People's privacy and dignity were largely supported and they were able to choose areas such as how they were dressed. Frail people who remained in bed were supported in considerate way by staff.

Visitors could come into the home as and when people wanted them to.

Is the service responsive?

Inadequate

The service was not always responsive.

People's care and treatment needs were not always met, including when people were at risk of pressure damage and people who had dementia care needs.

Summary of findings

Social engagement was not supported by the provision of an effective programme of activities.

Systems for consultation with people did not ensure all of their concerns were documented and acted upon.

Is the service well-led?

Inadequate 

The service was not always well-led.

The provider's systems for audit had not ensured that identified actions from the last inspection had been addressed.

Auditing of areas relating to people's quality of life and safety did not take place in all appropriate areas.

Relevant records relating to people's care and treatment were not always drawn up, or were incomplete.

Staff felt they could raise issues if they needed to with management. They were aware of how to ensure they followed the home's philosophy of care.

Harecombe Manor Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 7 and 9 September 2015 and was unannounced. The inspection was undertaken by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We reviewed the provider information return (PIR) and used this information when planning and undertaking the inspection. The provider also sent us some information immediately after the inspection.

We met with 25 people who lived at Harcombe Manor and observed their care, including the lunchtime meal, medicines administration and activities. We spoke with 7 people's relatives and visitors. We inspected the home, including people's bedrooms, sitting rooms, dining room and bathrooms. We spoke with eleven of the staff, including registered nurses, care workers, a domestic worker and the chef. We met with the registered manager and the provider. We also spoke with two visiting external professionals.

We 'pathway tracked' six of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

People said they felt safe in the home. One person told us, "The people around you make you feel safe," another said it was the overall feel of the place that made them feel safe. A person said as staff "pop in," they felt safe, especially when they were in bed at night. People said their medicines were given at the right time, one person said staff always came with their eye drops at night. A person told us if they had a headache, a painkiller would be given.

However we received a wide range of comments from both people and staff about staffing levels. One person told us there were "Not enough staff here," another "I never think there's enough staff," a person who remained in bed all the time told us "They don't come round often." People told us staff did not always respond promptly when they used their call bell. One person said if they rang their bell it "Varies so much," another person said "You wait so long." A person's relative told us they could wait five to 10 minutes for the bell to be answered and it was "Slower at weekends." Staff confirmed this was the case. One member of staff told us "We are struggling with staff at present" and another that there were not enough staff and weekends were "Always worse." A care worker said how "Guilty" they felt when they heard a call bell going as they could not often leave the person they were caring for to make sure it was answered. A registered nurse told us they often had to stop when they were giving out medicines to answer call bells to support people. The deputy manager said they were aware some paperwork was not up to date, this was because the people living in the home "Come first," this meant were too busy at times to do all the paperwork which needed to be done.

On 7 September 2015, we were in the sitting room for the whole morning, several people spent their time in there but the only time a member of staff came in to the room was to bring a person in to it. They did not stay and support people, this was despite people who were assessed as being at high risk of falls and people with high dependency needs being in the lounge all morning. On 9 September 2015, at 2:28pm we went into the sitting room because we heard a person calling out repeatedly. There were no staff available to support the person. Another person was also calling for help because they wanted to go to the toilet. We rang the bell for them. There was no response after five minutes, so we went to find a member of staff to support both people. This member of staff apologised to us and said they had not been able to respond because they had been busy supporting a person in their room.

We discussed with the registered manager how they assessed if they had sufficient staff to meet people's needs. We asked if they did dependency assessments and/or a staffing analysis, to establish how many staff were needed to meet the needs of people currently living at the home. They said no formal, written assessment of people's dependency needs or staffing analysis took place. They reported there were difficulties in recruitment of staff in the area and they did not have many potential staff applying for posts. They did use agency staff but this could be variable with agencies not always able to supply the home's needs. For example on 9 September 2015, the deputy manager told us the agency had not been able to supply the staff they needed. We asked the registered manager if they had any plans to ensure there were enough staff with sufficient skills to meet people's needs. They described actions they had considered. These had not yet been actioned.

The lack of effective systems to ensure the home had enough staff deployed to meet people's care and treatment needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a range of areas where people's safety was not ensured. At the last inspection we identified some people did not have a full risk assessment of all their needs carried out. After the inspection, the provider sent us an action plan in which they stated they would ensure detailed planning and additional risk assessments for people. This had not taken place.

We met with a person who staff confirmed remained in bed all the time. The person had a pressure damage risk assessment which had last been last reviewed on 5 June 2015. This assessment had not been correctly carried out or reviewed when relevant. This included the person's weight being recorded as 'average' when records of their weight showed they had a very low body weight. Their risk assessment had also not been updated when the decision was taken that the person was to remain in bed all of the time. This meant the person was assessed as being at a lower risk of pressure damage than they would have been if the assessment had been correctly completed. The person's care plan was dated 8 March 2015. This also

related to when they were more active. The mattress on the person's bed did not relate to a person who had a high risk of pressure damage. Their notes did not document any reasons for their not needing a specialist mattess. Appropriate action had not been taken to ensure this person was protected from the risks of pressure damage.

Other people's safety was not ensured. A person told us they had a history of falling and had recently fallen, sustaining a fracture to their hip. The person said they could stand up and use their frame but they tended to shuffle, particularly as they had sustained a pressure wound to their foot while they were in hospital.They said they knew they were meant to ring the bell for assistance but did not always do so, because it took staff so long to answer the bell when they rang. Staff said the person's recent fall had affected their mobility and confidence when walking. They said the person was encouraged to ring their bell when they wanted assistance but were aware the person did not always do this. The person had a table and a stool in front of the chair they sat on during the day. A range of objects they wished to use in their daily life were placed on the table, the stool and on the floor beside them. These objects could have presented a tripping risk to the person. The person's falls risk assessment did not take into account the effect to the person of their sore foot or loss of confidence. The person's care plan dated 19 August 2015 was not accurate as it stated they were to have a commode near them for them to use. The person did not have a commode and they told us they used their en-suite. There was no assessment of risks to the person from how they wanted their room to be set out or plan about how these risks were to be reduced.

We met with another person whose records showed they had fallen 15 times since 1 January 2015. Their care plan of 21 January 2015 stated they needed close observation to keep them safe and they were to have a sensor mat by their bed. On both days of the inspection the person spent all of their time in the sitting room. No member of staff was allocated to support people who spent their day in the sitting room. There was no assessment of how the person was to be kept safe while they were in the sitting room. The person did not have a plan to ensure their safety in the sitting room, such as provision of aids or a member of staff to check regularly on their situation.

The lack of effective systems to ensure the safety of people is breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found people were not protected against the risks associated with unsafe use and management of medicines. The provider sent us an action plan following the inspection. This outlined actions they would take in relation to prescribed skin creams. It did not report on other areas included in the report like the safe management of 'as required' (PRN) medication. The home's medicines policy, did not have any instructions about the administering of PRN medicines in line with guidelines from bodies like the Nursing and Midwifery Council (NMC).

We found the home had not taken all relevant actions to reduce risk to people from admintration of PRN medicines. One person was prescribed both a PRN painkiller and mood altering medicine. The painkiller was prescribed as a variable dose. This medicine had been given to the person on at least six occasions during September. A record had not been made of the actual amount administered to them, to ensure accuracy of the person's medicines' administration record (MAR). The person did not have a PRN protocol or care plan to state the reasons they needed to be administered either their painkiller or mood altering drug to ensure staff administered these drugs in a consistent way. A different person who had difficulties in communication was prescribed a painkiller to be administered four times a day. This person was being administered the medication three times a day, on a regular basis. They also had no care plan or protocol about administration of the painkiller, and no further information on the painkiller's affects, to ensure appropriate information was available for the prescriber of the benefits or otherwise for the person.

Effective management of medicines was not ensured in other areas. We met with a person on 7 September 2015 at 11:25am. They had a tablet on the table in front of them. We checked the person's MAR, it had been signed to show the tablet had been taken by them at 8:00am that day. We found the same situation on 9 September 2015. The home's medicines policy stated the MAR was to be signed only after the registered nurse has verified that the person had taken their medicine. Staff were not following the provider's policy on the safe administration of medicines..

Inadequate

Is the service safe?

When medicines were being given to people we heard a person ask the registered nurse to leave the tablets with them for them to take later, which the registered nurse did. This person did not have any risk assessment about self-medicating to ensure they were safe to take their medication on their own, and risks to other people were minimised.

The lack of effective systems to ensure safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see elements of good practise when medicines were given. We observed a registered nurse administering medicines. They carefully checked each prescription. They locked the medicines trolley when they were not with it. They supported each person by offering them a drink to enable them to take their medicines. They were polite and supportive to each person as they performed their role. We checked the medicines storage area. All medicines were securely stored. Medicines cupboards were kept in an orderly manner to support stock control. Records were maintained of temperatures to ensure medicines were safely stored at the correct temperature.

We spoke with five staff about how they safeguarded people who may be at risk of abuse, discussing a range of scenarios with them. Two of these staff said they would perform a brief investigation to verify matters first, before referring the allegation on to the appropriate person, rather than alerting the appropriate person at once, in accordance with the home's policy and procedure. All of the staff confirmed they would always report any allegation to their line manager or the home manager. Staff all knew about how to make a referral to the local authority if they needed to. The deputy manager was fully aware of their responsibilities for making referrals to the local authority of any allegations when the registered manager was not on duty.

At the last inspection we found people were not supported by recruitment procedures which ensured relevant information was in place. Since that inspection, the registered manager had reviewed staff records to ensure relevant documents were on file and had made a note of relevant matters where information could not be obtained. Only one new member of staff had been recruited since the last inspection. This new member of staff had relevant documentation to show safe recruitment procedures had taken place.

At the last inspection we found people, staff and others were not protected against risk of acquiring infections and appropriate standards of cleanliness and hygiene were not maintained. The provider had taken action to rectify this area. A person commented on the quality of the cleaning saying it was "Nicely done." A domestic worker had a full understanding of their role in ensuring hygiene and infection control practice. All parts of the home were clean, this included the undersides of bath hoists, undersides of raised toilet seats, the sluice rooms, commode chairs and commode inserts. Staff used disposable gloves and aprons and disposed of them safely after use. They washed their hands after removing disposable gloves and aprons and after any risk of contamination. The provider had purchased new linen trolleys, so clean and used laundry was fully separated. A new washer disinfector was being fitted to the sluice room when we inspected, to ensure appropriate sanitisation of items used in personal care.

The provider had invested in equipment to for the safety of people. A person said they liked their new hospital bed which made them feel safe. Three new hoists to support people in moving had been provided. We saw these were regularly used by staff. Equipment was regularly serviced. People who needed assistance from staff to move had their own slide sheets in their room, which had been allocated to them.

Inadequate

Is the service effective?

Our findings

We received mixed comments about the effectiveness of the service. One person told us some staff were good but others needed more training. However other people did not echo this. One person said "They all seem capable" about the staff and another "Very pleasant girls, even the agency staff know what they're doing." People also gave us mixed views about contacting external professionals. Two people said they felt the health care provided was not always good. However a different person told us a doctor would be called if they were unwell, and it would be done quickly. Another person said staff were "Pretty good" about getting their GP in. People gave us positive comments about the food. One person told us "There's quite a variety" about the food and another person told us the food was "Jolly good." A person told us "They're pretty good if there's anything I really dislike."

At the last inspection we found the provider did not have arrangements in place for acting in accordance with people's consent. After the inspection, the provider sent us an action plan in which they stated a document had been adapted to show each person had consented to care and treatment.

Several people living in Harcombe Manor Nursing Home remained in bed all or most of the time, with bed rails raised. We looked at records for four of these people. Two of the people had an assessment which showed they lacked capacity, one person's mental capacity assessment was incomplete and another person did not have a mental capacity assessment on file, although their records showed they had a diagnosis of dementia. Therefore the provider had not ensured it had followed their action plan for all people.

The provider's policy on the deprivation of liberty safeguards (DoLS) reflected current guidelines. This policy was not being followed. Three of the people had a hand-written note that the use of bed rails had been discussed with their next of kin, but nothing more. There was no evidence a best interests meeting involving all relevant parties had taken place when the decision was taken that these four people should remain in bed all of the time. None of the people had been referred to the local authority under DoLS in accordance with the provider's own policies.

The lack of effective systems to ensure the home had acted in accordance with the Mental Capacity Act 2005 to ensure people's consent to care and treatment, including where people may be at risk of being deprived of their liberties is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person told us they preferred to remain in bed due to a medical condition, but would like to get out of bed to use the toilet or a commode. They were not able to do this comfortably with the equipment and furniture they had been provided with by the home. We asked staff why another person remained in bed all of the time. Staff told us the person had contracted limbs so needed to remain in bed for their comfort and safety. We asked about a different person who remained in bed all of the time and were told the person was not able to sit comfortably, so was at risk of falling out of their chair. None of these people had been referred to an occupational therapist or physiotherapist to assess if specialist seating or other therapy intervention could enable them to get out of bed safely, sit out in comfort, encourace their independence or provide them with an alternative to remaining in bed all the time.

Staff told us about one of the people who could show behaviours at times such as "Fighting them off," when they tried to support them with eating , drinking or having a wash. Another person had records which showed they could be verbally aggressive to the extent where they needed to be taken out of the sitting room so as not to upset other people. Neither person had been referred to a mental health professionals such as a community psychiatric nurse to assess if interventions other than medication could be affective in supporting these behaviours which could challenge.

The lack of effective systems to ensure timely care planning, with other relevant health care professionals is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did ensure other people were supported appropriately by healthcare professionals. Two of the people had detailed instructions from a Speech and Language Therapist (SALT) available in their rooms. These specified supports staff were to give to the people to enable them to swallow safely. We saw staff following these instructions correctly.

Inadequate

Is the service effective?

People's records showed staff worked closely with people's GPs. This included a person who was very frail whose condition could vary on a day to day basis. Staff told us about how they were supporting the person and of their regular contacts with their GP to ensure the person was as comfortable as possible. This was fully documented in their records.

At the last inspection we found that people were not protected from the risks of inadequate nutrition and hydration and people who needed assistance did not receive the support they needed to eat and drink sufficient amounts for their needs. The provider sent us an action plan after the inspection in which they stated all people who could not eat and drink independently would have a food and fluid chart put in place to monitor their intake.

On both 7 and 9 September 2015, there was a tray of drinks and glasses in the sitting room, people did not have drinks placed by them and staff did not routinely offer people drinks when they came into the sitting room. The majority of the people in the sitting room had mobility difficulties, so could not go and get themselves a drink independently. We found similar concerns for people who remained in their rooms. At 2:24pm on 7 September 2015, we visited a person who remained in bed all of the time. They did not have a drinking glass in their room. Their visitor said the person had often told them they were thirsty when they visited. We visited a different person at 10:55am on 9 September 2015. They had a beaker of fluid placed on the table by their bed. The person had been placed on their left side but the table was on the right side of their bed, so they could not reach or see their drink. The same situation continued at 2:30pm. The person did not have any information in their care plan about what types of fluids they preferred to drink so staff, particularly agency staff, could ensure they gave the person drinks they liked.

The chef told us people needed assistance to maintain nutrition and hydration and 13 people needed full support to eat and drink. Staff said these people generally ate and drank well. We looked at records for three of these people, including the person whose drink was not placed where they could reach it. Records of these people's hydration did not support what staff told us. People's fluid intake was not totalled every 24 hours. When we totalled up people's fluid intake, their records showed these three people were drinking under one litre of fluids a day, which is significantly lower than the amount recommended in the Royal College of Nursing (RCN) guidelines for older people. These recommend "A conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day."

The lack of effective systems to ensure people's hydration needs were met is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However we there were examples of good practice with reference to food and drink. Where people needed help with nutrition, they were supported by staff. We saw a care worker sitting next to a person who needed full support to eat their lunch. They engaged the person in conversation while they supported them. They ensured the person had safely swallowed each mouthful before offering them a further mouthful. They were kindly and supportive to them. The chef told us they had a documentary system which ensured all people who ate their meals in their rooms could choose what they ate and received the meal they had chosen.

For people who ate in the dining room, mealtimes were a pleasant time, with people talking and socialising with each other. There was a choice of food which people decided on at the time of serving. The meal smelt appetising. There was fresh fruit available in place of a pudding if people wished. People sat at attractive, small tables which had cloth tablecloths and flower arrangements on them. Staff were available to support people if they needed.

Improvements were needed in staff supervision to ensure they were fully supported in providng effective care to people. The registered manger had a supervision plan. They said they were aware it was not fully up to date. This was because of staffing difficulties. We asked care workers if they were supervised, including in their day to day roles. They said registered nurses often worked with them and advised them of areas they needed to consider when caring for people. Registered nurses confirmed they did this. We asked how they documented any findings they made. They said they reported any issues verbally to the registered manager. We looked on staff files for records of such informal supervision sessions. Records were not maintained to enable review if all care workers received such supervision. The lack of such records also meant any issues of note could not be reviewed in the future if necessary. We asked two registered nurses about clinical

supervision, including supervision of medicines administration. They said supervisions of medicines administration did not take place and were not sure of processes for other clinical supervision. This means registered nurses may not be effectively supported in their clinical roles to ensure good practice, particularly in relation to safe medicines administration,care of people who were at risk of pressure wounds and dehydration.

Staff told us they had been trained in key areas like safe moving and handling of people, first aid and infection control. Training in fire safety was taking place when we inspected. None of the staff said they had been trained in the Mental Capacity Act 2005 or prevention of pressure damage. The registered manager gave us a copy of their current and future training plan. This confirmed what staff told us about training in key areas. The training plan did show dates were planned to train staff in their responsibilities under the Mental Capacity Act 2005, diet and nutrition and prevention of tissue damage, however it had not yet been delivered.

One new member of staff said they had received an induction into their role, they had already worked in the home in a different role, so were already aware of issues such as fire safety and the emergency policy. They said they had not yet been long enough in post to receive their three monthly probationary review. We met with an agency care worker who said they had been inducted into their role when they started working in the home. There was a file in the office which agency staff and staff in the home completed, to confirm they had been informed of key areas like fire safety when they started working in the home

Requires improvement

Is the service caring?

Our findings

We received mixed views about the care provided. Two people felt the care was arranged to suit the staff and not the people living in the home. A relative told us their loved one didn't get the care they deserved. This was not echoed by other people who said staff treated them with dignity and respect and felt they were looked after properly. One person described the care as "Good," saying "I get the attention I want."

We received a wide range of comments from people who felt staff did not attend to them quickly enough when they needed the toilet. A person described their mobility difficulties and said they did not like having to wait quite a long time for staff to come to help them go to the toilet. Another person told us that it was "Very awkward when you want the toilet and they don't come." A person described how they hated it when they became "Wet" because they had to wait for help. Another person said they had difficulties with their continence because of the time it took staff to respond when they asked for help. They said it was "Absolutely revolting, bit of a mess when that happens." We observed call bells rang frequently throughout the inspection. Two people had care plans which stated they needed prompt assistance if they rang their bell to ensure their continence and comfort. Staff said they responded as quickly as they could when people rang their bell but there were not enough staff to ensure they could always respond promptly when people rang.

People told us the staff didn't really have time to talk to them, as they were all very busy. One person qualified this by saying they liked the staff because they listened to them, although they didn't have much time, but when they were with them, they listened to them. When staff brought people into the sitting room, they did not stop and pass the time of day with people already there but left at once to support other people who needed their assistance.

The provider had not identified staff were not responding to people when they needed support and had not taken relevant actions to ensure people's needs were met, their dignity maintained and that staff had time to interact with people in a supportive manner. Because the provider had not identified these issues, this is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff attitude to people was mixed. When we asked a care worker at the end of the day to assist a person who was asking to go to the toilet, they responded to us by saying the person "Always says that," about asking to go to the toilet. The care worker was towards the end of their shift and looked visibly tired. However, during the morning we heard two care workers assisting a person in the bath, we could hear they were all joking and laughing together, clearly all three people were enjoying this engagement

When we asked people about privacy they seemed resigned to whatever happened. For example, we asked about staff knocking on their doors, one person said, "I'm so used to them coming in, I don't know. Another said, "Staff knock most times." We observed registered nurses giving out medicines, they always knocked on people's doors before they went into the room, saying who they were, to remind the person. Staff respected the privacy of people who remained in bed. During the morning, we knocked and went into the room of a person who remained in bed all of the time. The person was clearly in the middle of being supported to have a wash when their care worker had been called away. The care worker had ensured the person was fully covered by a sheet while they were out of the room.

People gave us mixed views about being supported in choosing how to live their lives and if their independence was supported. One person said they knew it was time to go to bed when a member of staff switched off the television. Other people said in general they choose what time they went to bed. People said that they could choose how they spent their time, but said mostly they just sat in the sitting room and didn't do anything. All people said that they chose what clothes they wore. One person who had difficulties in communicating with words had been supported to wear make-up, which had been carefully applied, they had beautifully painted nails and were wearing a range of jewellery as they had wished. They were smiling and relaxed. A person said they were trying to be more independent and they appreciated staff let them "Do what I can for myself." While we were with a person, the registered nurse knocked on their door before they came into their room and asked if wanted their wash or would prefer to continue to talk to us. The registered nurse listened to what the person said and respected their choice to continue to talk to us and said they would return later to support the person.

Requires improvement

Is the service caring?

Staff were supportive of very frail people. The first day of the inspection was a sunny day. A person who remained in bed and could not move themselves had sunlight coming brightly in through their window. A care worker took the time to go back to the person several times to adjust their curtains, so they could see out of the window, but the sun did not come directly into their eyes. When we spoke with staff, they knew about people as individuals, including how often they received visitors. This included an agency care worker who had clearly been briefed on different people's needs.

Visitors said they could come and go as they chose. Several people were being visited during the inspection. We wet with one person who said they and their sibling nearly always came in to support their parent with eating their lunch. They were pleased the home were happy for them to do this. Visitors told us that generally staff were pleasant and friendly, to both people and themselves.

Inadequate

Is the service responsive?

Our findings

We asked people about their care plans and received mixed responses. Several people said they didn't know anything about their care plans and had never had them explained. Two relatives told us they had not been involved with the planning of the person's care plan but they were given it to read and were asked to sign it. However one person said they felt they had been very involved in planning their care and staff followed what they wanted. Another person said "If you're poorly, they look after you."

At the last inspection we found people were not protected against the risks of receiving care and treatment which was inappropriate or unsafe. This was because people did not have their care planned and delivered to meet their individual needs and ensure their welfare and safety. The provider sent us an action plan which stated the registered manager would put a more detailed care plan in place for each person. The care plan for each resident would be updated monthly with the person and their next of kin.

At the last inspection, we found a range of areas where people's risk of pressure damage was not reduced. National Institute for Health and Care Excellence (NICE) guidance on prevention of pressure wounds stated because pressure wounds, once developed take an extended period to heal, can be painful and may present a risk of infection, the emphasis must always be on their prevention. At this inspection, the service continued not to respond to people in an appropriate way when they needed care and treatment.

At the start of the inspection the registered manager told us about a person who had very recently developed a blister on their heel but said they did not have enough information yet to know if it was a pressure wound or not. We looked at this person's records. Their records showed pressure damage was first documented on 26 August 2015, 12 days before our inspection. Their care plan was not revised until 1 September 2015, six days after their pressure damage was first noted. Additionally an air mattress was not documented as being provided to them until the same date. By 5 September 2015, records showed the person's pressure damage had progressed and the area affected was now an open wound. Three of the staff said they were changing the person's position every three hours, and ensuring their feet were elevated on a cushion. When we met with this person at 4:45pm, their heel was on the bed because a pillow had been placed too high under their knee. Also their mattress setting was on 'firm,' not 'medium' as stated was required in their records. When we looked at their records these showed periods when they had not been supported in changing their position regularly, for example between 9 pm on 8 September 2015 and 2 am on 9 September 2015. We made a referral to the local authority about this person under safeguarding procedures in relation to this person's care and treatment.

Other people who were assessed as being at risk of pressure damage were not supported appropriately. A person who was assessed as being at high risk of pressure damage had the setting on their air mattress for a person who weighed 127 Kilograms when their last weight was documented as being 36 Kilograms. Having an air mattress on the incorrect setting for a person's weight can increase their risk of pressure damage. We looked at movement position records for two other people who remained in bed all of the time and were assessed as being at risk of pressure damage. Staff also told us these people were to be turned every three hours, however they also showed periods when they had remained in the same position for periods in excess of three hours.

The lack of systems to ensure people's care and treatment was provided in a safe way to reduce their risk of pressure damage was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service were also not responding to appropriately support people who were living with dementia. Staff told us about a person who was living with dementia who could show verbal aggression, including swearing and raising their voice, and one member of staff said they had been known to throw things. The person's care plan stated they became angry easily and could show agitation. The person's daily record did not document any records of behaviours that may challenge. We asked staff if they maintained any other record of the person's behaviours so they could identify any trigger factors, map their duration and record action they took to reduce such behaviours. They confirmed they did not. Some staff said when the person showed behaviours which may challenge, they took them back to their room if other people were being affected by them. Other staff said they left the person as

they were until they were calmer. The person did not have any care plan about their dementia care needs to ensure staff responded in a consistent way when the person showed behaviours which may challenge.

At our last inspection, we found there was a lack of recreational activities provided to people. In their action plan, the provider did not detail actions they would be undertaking to develop activities for people. We asked people about activities provision, all of the people felt this was an area where the home was not responding to their needs. Comments included "No activities happen," "Nothing happens at all," "Don't do a lot downstairs." A person told us they were "Fed up" with there being nothing to do. A relative told us their relative was "Bored as there is nothing for them to do."

During the morning people sat in easy chairs in the lounge. No activities were provided, apart from the television. Most people were either asleep or sitting in chairs. In the afternoon, a care worker tried to get some activities organised. They tried to lead some singing but they didn't know the songs themselves and the people in the lounge didn't know them either. The care worker said they had tried to do bingo sometimes but that didn't work well either. We asked care workers about training in activities provision but they said they had not been trained in the area. We looked at records of activities provided to see if what we saw was representative of what usually occurred. Records of activities were very limited and there were no records that any activities had been provided on six of the days in the previous fortnight. Where activities records were maintained they did not detail if there were activities provided other than watching television to talking with small groups of people.

People who remained in their own rooms did not have activities provided apart from the television or music. Many of these people were in bed with bed rails up with bed rail protectors over them, so they could not see out of bed. Such people were totally reliant on visits from staff to provide stimulation to them.

Care plans had been developed about people's social needs. Some of these briefly documented people's past occupation and family history, but not all. Therefore staff, particularly agency staff, would not be made aware of people's backgrounds so they could converse with them about matters of interest to them when providing care. One person's care plan gave no indication of the activities or hobbies they would like to do apart from holding conversations. This person spent their time in the lounge on both days but did not have any specific activities provided to them. Another person who staff told us remained in bed all the time had a care plan which related to when they still got up and went to the lounge. A third person who remained in bed all the time had a care plan which stated staff should spend time with them during the course of the day to build up a relationship and promote trust. None of these people had records of any social activities documented. Staff told us they did not have time to support people in individual activities.

Guidelines on activities provision state that maintaining existing skills, as far as possible, can give the person pleasure and boost their confidence. Keeping people occupied and stimulated can improve quality of life for the people. The provider did not ensure this took place.

The lack of systems to ensure people's care was appropriate, met their needs and reflected their preferences in relation to their dementia and recreational activities needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In their PIR the provider stated 'We will ensure our service is effective by asking residents and relatives to comment on our services we will have regular meeting to ensure resident are listened to as to how the service is run. Their comments will be noted and acted upon.' The home had a complaints policy which was available to people.

We asked people about raising complaints and received mixed responses. One person said they had concerns but had "Not told anyone" about them. Another person told us they were nervous of raising a complaint because when they had done so in the past, the service had not been supportive to them. A person told us if they had a complaint they would tell one of the staff or, if possible, the manager. They said they were not sure if anything would change if they did complain. However other people were more positive. One person said they would speak "To one of the girls and they would pass it on," and another said "I should think so" about raising a complaint if they wanted to. Another person said "I don't have any complaints"

People said they felt they had raised issues, including about the lack of staff, lack of activities and slow response time to the call bell. Two people told us about certain

Inadequate

Is the service responsive?

specific issues which they informed us they had complained about to staff. We looked in the home's complaints book. None of these matters had been documented. Formal complaints had been documented and responded to in accordance with the provider's policy. We discussed with the line manager that some people may have felt they had raised a complaint by telling a member of staff. The registered manager said they would inform staff that all matters of concern and any verbal complaints should be reported to them so they could be made aware and take appropriate action where necessary.

We spoke with people and visitors about seeking their views via questionnaires, however none of them could recall being asked to fill out a questionnaire to provide their view of the care provided. The registered manager gave us copies of their audit of their most recent questionnaires for January to March 2015. Most responses were highly favourable about the care. However one did state the home needed to 'Arrange occasional trips out." Relatives said relatives meetings had been introduced since the last inspection, these were to happen every three months. Relatives were positive about these meetings.

Inadequate

Is the service well-led?

Our findings

We received mixed comments about what people felt about the home. One person said the home had a "Mediocre atmosphere," and another person said "I don't think it's that good." One person said they did not find the manager was approachable when they raised issues. A person said the home was "All right, I think." Other people were much more positive. One person said "I'm happy here," another "It's lovely" and another "It's very good, I like it." A person said they liked the home because "I'm being looked after" and another "I feel secure, I sleep well and I can have visitors."

At the last inspection we identified that people and others were not protected against the risks of inappropriate or unsafe care and treatment. This was because systems to regularly assess and monitor the quality and safety of the service were not effective. We issued the provider with a Warning Notice to ensure they made necessary improvements. The provider responded to state the actions they would take. This included the registered manager and quality assurance manager ensuring improvement was sustained by carrying out audits to ensure compliance. In their PIR, the provider stated 'We plan to make the audit systems that we have introduced completely robust.'

We found a range of areas where the provider's systems had not been effective or robust. The provider had not identified that they continued not to address certain areas identified at the previous inspection. This included ensuring relevant capacity assessments were in place for people where they were living with dementia and that they had safe systems for the management of medicines. Where action plans were drawn up, they were not followed up on. For example it was stated in one of the home's own action plans that there were to be 'more activities and events,' with a target date for 1 June 2015. This had not taken place. There had also been no evaluation of this action plan to ensure quality of service to people was improved.

We were given copies of the provider's monthly reports on visits to the home, these did not review progress on areas of non-compliance identified in the previous report, apart from the report for April 2015 and September 2015 which reported on specific issues relating to infection control. The provider's monthly reports had not considered significant areas raised by people, including concerns about staffing levels, response time to call bells and the lack of activities provision.

Because people raised issues with us about response time to call bells we asked the registered manager how they assessed how long it took for staff to respond to people when they used their call bell. The registered manager said they did not have systems to enable them to do this. This meant they could not analyse how long it took on average for staff to respond when people used their call bells and if they considered such response times ensured people's health safety and welfare.

We asked the registered manager about how they monitored accidents to people. They gave us their audit, which listed people's names and the date when accidents had occurred. The records they showed us did not monitor any other factors to identify risk, so action could be taken to reduce people's risk. We looked at accident records for June, July and August 2015. These showed there were thirty recorded accidents in this period of time. Of these, 29 records were unwitnessed and the accident had happened when people were alone in their own rooms. The period of time between when a person had their accident and before they were supported by staff was not clear from accident records. For example a person was recorded as having been found at 10:50pm. They were found lying on the floor. The person was subsequently found to have sustained a fracture. No information was available about how long the person had remained in discomfort on the floor of their room. When we looked at times when people fell, most had happened from early, through to later evening. None had occurred during the morning. As there had been no analysis of the accidents, the provider had not identified areas to audit such as why most falls were unwitnessed, why the majority occurred at similar times of day and how long people waited after an accident before they were supported by staff. Actions had therefore not been taken to improve the safety of people.

The systems for audit had also not identified the home was not following its own policies. The service's own fire risk assessment stated all people were required to have a Personal Emergency Evacuation Plan (PEEP) in the event of a fire. It stated these PEEPs should be continually monitored and adjusted in accordance with the person's health and mobility. We asked to look at people's PEEPs.

Inadequate

Is the service well-led?

The registered manager said that they did not have PEEPs drawn up for people. The provider's audit systems had not identified such plans were not in place to ensure the safety of people in the event of fire.

Where records were maintained they did not enable evaluation or review of a person's care. People's food intake charts generally did not state what the person had actually eaten, with records such as 'pureed meal' or 'pureed meat,'' not the quantity and type of food a person had actually eaten. One person had a care plan dated 25 May 2015 which stated they needed 'a well-balanced diet.' The records maintained were not sufficient to ensure staff could assess that this person's goal had been met.

The provider did not have effective systems to assess, monitor and improve services to people and mitigate their risk in relation to meeting their health and safety needs. They were not ensuring they had an accurate and complete record of the care given to people. This is a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had taken certain actions to ensure the health, safety and welfare of people. At the last inspection, we had identified issues relating to hygiene and infection control. The home was now clean and hygienic and we observed staff followed appropriate infection control practice. At the last inspection, we had identified bed rails were not being used in a safe way. The provider had taken action to ensure all bed rails were safe and were fitted in accordance with guidelines.

Other issues had been identified by the provider's audits. We noted that several of the windows on the first floor were unsafe in that they did not comply with guidelines on window restrictors from the Health and Safety Executive. The registered manager told us this had been identified and they showed us new window restrictors which were to be installed to ensure the safety of people. We identified some fire doors did not fit into their door frames and so could present a risk of fire and smoke inhalation in the event of a fire. These had been identified and action was being taken to ensure their repair.

The service's philosophy of care was displayed in the entrance hall and was provided individually to people in the statement of purpose. The philosophy stressed the importance of professional nursing care in a homely environment. Staff were aware of the philosophy. One member of staff stressed the importance of giving good care to people and another reported on the importance of equality and ensuring that people did not experience discrimination. Staff said most of them had worked in the home for a long time and worked effectively to support each other, and were flexible in their roles. Care workers said registered nurses supported them by performing caring roles when needed. Registered nurses said they were happy to do caring roles when needed, because the care needs of people "Came first."

Staff meetings took place. We saw minutes of the most recent staff meeting were available in the staff office for any member of staff to review. This showed just over half of the staff employed had been able to attend the most recent meeting. Staff said they felt they could raise issues during staff meetings and supervision. One member of staff's supervision record documented "Staffing issues affect morale at times" and another "Over workload due to short staff." One care worker said "I'm very vocal, me" and said they felt they would be listened to, another member of staff said "Yes they do listen" when they raised issues.

This section is primarily information for the provider

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

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

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 was not ensuring the care and treatment of people was appropriate, met their needs and reflected their preferences. They had not ensured people's needs were met in relation people who were living with dementia and ensuring people were provided with activities to support engagement. Regulation 9(1)(a)(b)(c)(3)(b)

The enforcement action we took:
The CQC will be taking legal action in line with our policies and procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Transport services, triage and medical advice provided remotely	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider had not ensured an assessment took place where people may not have the capacity to consent and ensured people were safeguarded against the risk of being deprived of their liberties. Regulation 11(1)(2)(3)(4)(5)

The enforcement action we took:
The CQC will be taking legal action in line with our policies and procedures.

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 was not ensuring care and treatment was provided in a safe way for people by assessing risks to the health and safety of people and doing all that was reasonably practicable to mitigate such risks. They were also not ensuring the proper and safe management of medicines. They were not ensuring timely care planning took place with relevant external professionals for the health, safety and welfare of people.

This section is primarily information for the provider

Enforcement actions

Regulation 12(1)(2)(a)(b)(g)(I)

The enforcement action we took:
The CQC will be taking legal action in line with our policies and procedures.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems to ensure they assessed, monitored and improved the quality and safety of the services provided, and their systems did not mitigate such risks to people. They were also not maintaining an accurate, complete and contemporaneous record for each person. Regulation 17 (1)(2)(a)(b)(c)

The enforcement action we took:
The CQC will be taking legal action in line with our policies and procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was not ensuring sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet people's needs. Regulation 18 (1)

The enforcement action we took:
The CQC will be taking legal action in line with our policies and procedures.