Four Seasons (DFK) Limited

Meadowbrook Care Home

Inspection report

Twmpath Lane
Gobowen
Oswestry
Shropshire
SY10 7HD

Tel: 01691653000
Website: www.fshc.co.uk

Date of inspection visit:
04 April 2017
05 April 2017

Date of publication:
22 June 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was carried out on 4 and 5 April 2017 and was unannounced.
The home was last inspected on the 14 September 2016 where we gave it an overall rating of requires improvement. We had identified the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach related to a lack of person centred care. We asked the provider to make improvements and send us an action plan. At this inspection we found that improvements had not been made and that further concerns were identified.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Meadowbrook Care Home is registered to provide accommodation with nursing care for up to a maximum of 79 people. There were 50 people living at the home during our inspection. People were cared for in three units. These included the Garrett Anderson unit which provides supports to people living with dementia. The Mary Powell Unit which provides support to people with physical health needs and the Agnes Hunt unit which supports people living with neurological needs.

There was a registered manager in post who was absent during our inspection. 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.

There were not enough suitably trained staff deployed to meet people's needs in a timely and person centred manner. There were staff vacancies and a high turnover of staff. There was a reliance on agency staff to cover the gaps in shifts. This added additional pressure to permanent staff as they had to show agency staff what to do as well as doing their own jobs. Staff felt stressed and morale was low.

Risks to people's health and well-being had been assessed and guidance developed to advise staff on the equipment and support required to minimise risk. However, these were not always reviewed or followed by staff. The provider did not ensure that people's environment was kept clean and hazard free.

People and their home environment were not always treated with respect and their dignity was compromised. People's information was not always kept confidential.

People were not always provided with personalised care suited to their needs. Staff had limited time to spend with people other than when providing personal care and were task led. There was a lack of stimulation and many people sat doing nothing for most of the time.

The provider had not always followed the principles of the Mental Capacity Act and people were unlawfully deprived of their liberty. Staff did not always seek people's consent before supporting them.

People did not always receive adequate support to help them eat their meals in a dignified manner. This placed people at an increased risk to their health and wellbeing. People had mixed views about the quality and choice of food available to them.

There was ineffective leadership at the home. People and their relatives did not find the registered manager approachable and lacked confidence in them and how the service was run.

Staff did not always feel that they were provided with the support and equipment they needed to enable them to do their jobs well.

The quality assurance systems the provider had in place to monitor the quality of care were not always effective in identifying and addressing concerns raised. The provider was keen to make improvements to the service and provided additional resource to achieve this.

The provider had systems to gather people's, relatives and staff views on the service but their concerns were not always acknowledged or acted upon.
People were supported to take their medicines as prescribed. Only staff who had training on the safe management of medicines administered them.

People were protected from harm or abuse by staff who knew how to recognise and report concerns. The provider had safe recruitment procedures which ensured that prospective new staff were suitable to work with people living at the home.

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 consistently safe.

People's needs were not always met because there were not enough staff employed or deployed to meet them. Risk management systems had failed to make sure people were safe and prevent them from experiencing further harm. Staff had training to enable them to identify signs of abuse and they knew how to report concerns.
People were supported by staff to have their medicines as they had been prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider did not always follow the principles of the Mental Capacity Act and therefore some people were unlawfully deprived of their liberty. Staff did not always feel supported in their roles.

People did not always receive adequate support to eat and drink.

People were supported to access healthcare as and when necessary.

Is the service caring?

Inadequate

The service was not always caring.

People were not always treated with respect and their dignity was compromised.

There was a lack of consideration and respect for people's experience of the environment.

People were not always given choice.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always received care and treatment that was individual and personalised to them.

People and their relatives were given opportunities to give their views on the service however, these were not always responded to.

Is the service well-led?

Inadequate

The service was not well led.

The service lacked effective leadership. Staff were unsupported and morale was low. The provider had insufficient oversight of the current areas for improvement in the service because the systems they had had in place to assess and monitor the quality of the service were ineffective.

Meadowbrook Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 5 April 2017 and was unannounced. The inspection was conducted by three inspectors, a specialist adviser nurse 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.

As part of the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We asked the local authority and Healthwatch if they had information to share about the service provided. We had received information from the local authority regarding concerns raised with them which they were investigating. We used this information to plan the inspection.

There had been continued concerns about people's care and treatment at the service and the local authority had maintained their suspension on admissions.

During the inspection we spoke with 16 people who lived at the home and six relatives. We spoke with 22 staff which included the four regional managers, the clinical and deputy managers, five nurses, 11 care staff, one kitchen staff member, two activity workers and three domestic staff. We viewed five records which related to the assessment of needs and risk. We also viewed other records which related to the management of the service such as medicine records, complaint records and the recruitment records for three staff.

We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were unable to talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that there were not enough staff suitably deployed to meet people's needs in timely manner. At this inspection we found improvements had not been made. People and relatives we spoke with felt that there were not always enough staff on duty and that there was an over reliance on agency staff. One person told us that they sometime had to wait an hour before staff responded to their calls for help. Another person told us, "Sometimes staff just walk past without answering the bell." A relative informed us their family member had been in the home several years and at first had found the care good but this had gone steadily downhill. They said, "The staffing is not good, if this inspection can do one thing please get the staffing sorted. There are too many agency staff who do not know the residents or their needs. There are plenty here today probably because you are here! There are never enough on at weekends – Why? It should be the same level of service 24 / 7 – 7 days a week." Another relative said, "[Family member] is happy here and has a nice room and we are broadly happy that they are okay. However, we think the staffing situation is a real issue especially at weekends. But you wouldn't know it was a problem today." In the afternoon of the second day of visit a relative came into the management team office. They asked the management team for support for their family member who had called for staff support an hour earlier. They said, "It's like the Mary Celeste out there, I can't find any staff to help."

Staff spoke of stressful working conditions where they were often short staffed or did not have the staff with the right skill mix to meet people's needs. They explained that there was a high use of agency staff. While the regular agency staff had got to know people well many of the other agency staff lacked experience and knowledge of people's needs. This placed further pressure on staff as they had to take time to explain people's needs and routines to them. One staff member told us, "There is a lot of agency. Some, like [Staff member's name], who comes a lot, are like regular members of staff but the others, when there are lots of different staff it is hard. We don't have the time to show agency staff what to do. By the time we have shown them we could have done it. It is not helpful." Another staff member said, "We have lost a lot of good carers. There are a lot of agency staff – not very good, no experience. We end up doing their jobs as well as ours."

There was a high turnover of staff at the home and a number of vacant posts. We observed that staff had limited time to spend with people other than when they were helping them with personal care tasks. This was confirmed by a staff member who told us, "Our days are task-led because of the lack of staff. We are trying to make it better but, some days, we feel as though we are swimming against the tide." Another staff member said, "Five years ago the care here was person-centred. Now it is all about getting through the tasks. We are overrun with paperwork. No time to sit with people because of constant form filling. We are run ragged, pulled four ways some days. Very high stress levels. I hope it gets better – we all want it to be better." Staff on the Garrett Anderson unit informed us it was often late morning before some people had their breakfast because staff were not available to help them feed them. This was confirmed through our observations and discussion with staff. For example, one staff member explained that they had washed and dressed one person, hoisted them to their chair and took them to the lounge to wait for the breakfast trolley at 8am. This person was not given a drink until 10.30am when staff supported them with their breakfast.

Three staff informed us they had spoken to the management team about staffing levels but felt they were

not listened to. One staff member felt it was like 'banging their head against a brick wall.' They told us that the management team kept referring them back to the dependency tool. However, staff felt that the dependency tool used did not take into account people's individual needs as many people required the assistance of two care staff. Staff also raised concern about the deployment of suitably trained staff. One agency staff member explained that on one day, there was an agency nurse, two new care staff and one new agency care staff member working on the unit. That meant that there was only one agency staff member who had any knowledge about the people living on the unit. People on this unit were living with dementia and were reliant on staff to interpret their needs and benefitted from consistent support from regular care staff. One staff member told us they had informed the senior managers of their concerns and they responded, "I am not doing the rota."

We spoke with the management team about how they monitored staff levels and response to calls bells. They said they continued to use a dependency tool to establish staff levels required to meet people's needs. In addition the management team completed 'walk arounds' of the home to monitor staff deployment. The management team confirmed the current staffing difficulties at the home. They had a continual recruitment drive in place but needed to employ agency staff to cover the vacancies in the interim. To establish continuity of care for people they were now planning rotas in advance and block booking agency staff to obtain regular staff. They said they were encouraging staff to communicate with staff on other units to ensure a better skill mix between the units.

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

People had individual risk assessments that provided staff with guidance on how to support them safely. These included risks associated with people's mobility and skin integrity. However, we found that staff did not always know what was in people's risk assessments. For example, a nurse told us some staff did not always follow the risks assessments in place. They said, "Yesterday carers were going to use a small sling on a big person." They stopped them and told them to go and get the correct sling from another unit. We observed two staff members use an unsafe lifting technique to help a person transfer from their wheelchair to an armchair. The use of this technique put both the person and staff involved at risk of injury. It also contradicted the guidelines in the person's moving and handling risk assessment.

A staff member on the Garrett Anderson told us, "The unit manager left before Christmas after working here for 20 years. They left a big void." They went on to tell us there was not a permanent nurse working days on the unit. Staff felt this impacted the quality of care people received as no one took responsibility. For example, one staff member informed us that a relative had raised concerns about their family member's pressure sores. They said, "There is no permanent registered nurse to monitor their feet and they are getting worse and worse." We looked at the care records for this person and found that records were incomplete and it was difficult to track the person's skin care management. When we spoke with the senior managers they told us they had since put a 'tracker' in place to monitor the effectiveness of people's wound care. This system had been newly introduced and therefore we were unable to report on the effectiveness of it at this inspection.

There were building works being completed at the home as part of the on-going refurbishment and modernisation of the building. We found that the provider had not considered the risks to people and did not always ensure a safe and hazard free environment for them. On the Garrett Anderson unit a bedroom was being used as storage area. The door to this room was held open and we saw that the items stored in there posed a trip or injury hazard to people living on the unit. We saw one person living with dementia had entered this room, we helped them out and closed the door. We spoke with the management team who said

they would arrange for the door to be locked. We saw a series of other hazards on this unit which included a door wedged open with a claw hammer which was sticking out. We had to draw the builder's attention to the trip hazards this posed; we saw that a small laundry trolley had been left in the corridor and had to bring this to the attention of staff as it posed a trip hazard to people living on the unit. People living on this unit relied on care staff to maintain their safety however, these hazards had not been identified or addressed by staff on the unit or the management team during their walk arounds.

On the Mary Powell unit we noted a large spillage of milk on the dining room floor where a person was seated at the table. We saw one member of staff walk pass the spillage several times, another staff member sat and ate at this table. Over a period of 45 minutes we saw four care staff and one senior manager in the dining area and none of them took action to remove the spillage. We then approached a staff member and asked whose responsibility it was to clear up the spillage. The staff member replied, "The person who spilt this."

We found some areas of the home were not always kept clean and that staff had not always considered infection prevention and control. We spoke with a relative on the Mary Powell unit they said, "It breaks my heart to see how they run the kitchen here and the dining room. It's dirty, people wandering in and out all the time – the traffic through the kitchen should not happen because of health and safety and control of infection." We observed the builders walking in and out of the dining area and leaning on the area where food was being served. We also saw a dirty table that was sticky and covered in crumbs.

On the Garrett Anderson Unit we saw a toilet was cluttered with mops, mop buckets, urinals, boxes of gloves and cleaning signs. The toilet was not locked. We spoke with staff about the accessibility of the toilet for people living on the unit. The nurse on the unit was not aware of the items being stored in there. However, the maintenance person told us the toilet was being used as a sluice while the building work was being carried out. In one bedroom on this unit we found that a person's mattress was soiled. We also saw ants on one of the dining tables in this unit where people were expected to eat.

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

People felt safe living at the home but two people were apprehensive about the high turnover of staff. One person told us, "I do like it here and always felt safe and looked after but now all the nice ones are leaving which is a real shame as I don't know people and it feels funny." Another person said, "I feel safe here although a lot of the nice nurses who do look after us are leaving and I miss them. The others don't look after us the same and I don't much like some of them. It's then that you don't feel quite right as you don't know them or who they are." Two relatives we spoke with were not confident that their family members were always kept safe. One relative told us, "I come in every day to make sure [family member] is OK as they would never complain. I have to reassure myself every day that they are safe."

People we spoke with felt comfortable to report any concerns they had about their safety and wellbeing to staff or management. One person said, "If staff are nasty to us I would go to the office." They confirmed they had not experienced any abuse and found staff were 'alright'. People were supported by staff who had been trained to protect people from harm and abuse. Staff were knowledgeable about the different forms of abuse and were able to describe the potential signs of abuse taking place. These included changes in people's behaviour such as, withdrawal and fearfulness as well as the physical signs of bruising and injuries. Staff told us they would share any such concerns with the management team. Staff were also aware of other external agencies they could share concerns with to protect people from further harm.

We saw that the provider had recently reviewed people's personal emergency evacuation plans(PEEPs). The PEEPs identified the support people would require to leave the home safely in the event of a fire or other such emergency.

Staff demonstrated they knew how and when to report accidents and incidents. They made sure the person was safe and called for the assistance of a nurse. In the event of a fall the nurse completed a full body check and arranged medical attention if required. They subsequently completed the accident form and informed the person's relatives. Accident forms were monitored for patterns and trends and where appropriate referrals were made to other health professionals. For example, where one person had an increased number of falls they were referred to the GP who reviewed and changed their medicine.

Staff told us the provider had completed checks to make sure they were suitable to work with people living at the home. These included references from previous employers and Disclosure and Barring Service (DBS). The DBS helps employees make safe recruitment choices. Records we looked at confirmed that the provider followed safe recruitment procedures.

Requires Improvement

Is the service effective?

Our findings

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had not consistently followed DoLS. In the care records of three people's we looked at we found their DoL authorisation had expired before the provider had requested a reassessment. In a further instance we found a DoLS application that had been completed but there was no evidence that this had been submitted. Some staff were not aware who had a DoLS in place and the reasons for these. This is important because a DoLS may have conditions attached to them that staff need to follow to ensure the person's rights are protected. This could have an impact on how people's care is planned and delivered. We spoke with the management team who were unable to give us an accurate overview of the number of people who were subject to DoLS. The regional manager told us the information they held was not up to date as many of these people had left the home. As a result they were having to contact the local authority DoLS team to establish the status of DoLS applications, authorisations and review dates.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training on the MCA and some staff had a firm understanding of the Act. For example, one staff member told us they deemed people to have capacity unless proven otherwise. They explained that the MCA was decision specific. They said some people were able to articulate themselves well in some areas but when they 'scratched below the surface', they sometimes found the person did not understand more complex issues and required decisions to be made for them. Where this was the case they understood that decisions needed to be made in person's best interests and that they needed to consider the least restrictive practice. They explained it was important to involve the person as much as possible as although they could not make the decision on their own they could contribute. In doing so they said, "The moments of clarity you can get are beautiful." When we spoke with some staff we found they had limited understanding of the MCA and the implications for practice. Staff told us they always sought people's consent before supporting them and showed them different items of clothing to enable them to make decisions about what they wanted wear. We observed that staff did not consistently seek people's consent before supporting them. For example, at mealtimes we observed that some staff placed tabards on people without asking them first.

Staff had different views on level and quality of support they received from the management team. One staff member informed us they had one-to-one meetings where they were able to talk about issues of concern.

However, they were not confident that they this would make a difference. They said, "It was done for the tick in the box with the paperwork, not because they are bothered about my views." Another staff member explained that they had one-to-one meetings with a registered nurse but they felt they were not listened to as nothing changed as a result of conversations had. However, two other staff we spoke with found their one-to-one meeting helpful and were an opportunity to tell their supervisors how they felt about things that were happening in the home. One of these staff members said, "I can't praise [Nurse's name] enough. They're the go to person. You never feel that you can't go to them."

Staff we spoke with had varying opinions on the availability and standard of training. One staff member told us," When I first started here there was good training, and I had a good mentor. Over the past 12 months there has been a huge turnover of staff. New staff are not trained properly." As a result they felt 'The care has gone downhill.' Staff on the Garrett Anderson told us some people could present with challenging behaviours which put themselves and staff at risk of injury. One staff member felt competent to deal with such incidences. However, they recognised that some of their colleagues were not and had sustained injuries due to lack of training on how to support people to manage their behaviours. Another staff member told us, "There is no training to meet the needs of the residents. I have asked on numerous occasions for training on how to handle residents with challenging behaviour." They went on to tell us about incident that happened a few weeks earlier where staff had found it difficult to safely support a person who displayed challenging behaviour and they had sustained bruising.

Other staff told us they thought their training opportunities were good. The provider employed Care Home Assistant Practitioners (CHAP) who were care staff who had undertaken additional training to enable them to complete and support nursing care tasks. The CHAPs spoke highly of the training opportunities and told us they were supported to maintain and enhance their skills through reflective diaries and refresher training. One CHAP also told us they hoped to access nurse training through the provider in the future. Other staff told us training had recently improved. For example, one staff member told us they had recently completed behaviour training. They felt they had learnt a lot about people's behaviour and were now more able to recognise when people were upset and why. Another staff member had recently completed training on Huntington's disease. They felt this had given them insight into how a people living with the disease took in and processed information. On the whole staff told us they preferred face-to-face training. One staff member said, "We are having face-to-face training which we have been asking for, for years. E-Learning is not a challenge, if you get it wrong tick another box until you get it right."

One new staff member told us during their induction they were given information on the policies and procedures as well as practical training to meet the needs of people living at the home. They had found the 'resident experience' training particularly beneficial as it had shown them how not to treat people. They said, "It struck with me like a rock." New staff who had not had experience of working in care were supported to complete the Care Certificate. The Care Certificate is a nationally recognised training programme aimed at training staff to recognise the standards of care required of them.

We found that agency staff induction into the service varied. The agency nursing staff told us they were given a detailed overview of how the service was run. They were also given information on people's needs and the support they needed. One agency nurse told us, "You have to work with staff and have to be hands on." They went on to explain this promoted a team approach to meeting people's needs. Another agency nurse told us that an overview of people's needs was held within the medicine administration records and they were able to refer to this when needed. If they were unsure about anything they said they spoke with other staff who were more familiar with people's needs. An agency care staff member told us when they first started working at the home they worked alongside other staff, were shown fire exits and where the wheelchairs were kept. Permanent staff we spoke with felt that some agency staff did not have adequate preparation for the jobs

required of them. One staff member said, "They (agency staff) just come in and you have to teach them things."

People we spoke with had different views about the quality and choice of food available. One person told us, "The food is very good." They went on to tell us that staff brought a menu around and they were able to choose what they would like to eat. If they did like not the options they could have an alternative. Another person felt the food was not good, they said, "We don't get a lot of choice. Most of the time it is cold and it seems to be the same thing every week." We observed that people were not always offered choice about what they wanted to eat. On the Garrett Anderson unit we heard staff discussing what people could have for dessert. We saw that the staff made choices without any consultation with the people they were supporting.

People's nutritional needs had been assessed and where there were concerns about what they ate and drank monitoring charts had been put in place for staff to ensure adequate intake. However, we found that these were not always consistently completed. On the Garrett Anderson unit we saw one person's fluid intake was below the recommended level. We spoke with the nurse who explained staff did not accurately record people's intake. A relative told us that their family member's care plan stipulated they were to be encouraged to drink plenty. However, they were not confident that staff supported them to do so. We observed that people did not always receive adequate support to feed themselves. At lunch time on the Mary Powell unit we observed a person struggling to feed themselves in full view of staff. The person had spilt all of their food on to their lap and had not managed to eat any of it. Staff removed the person's plate, food stained tabard and blanket. Staff then served the person dessert but again they struggled to feed themselves and at the end of the service they banged the table with their spoon. A staff member who was supporting another person asked them what was wrong and gave them two spoonfuls of pudding before going back to the other person.

The cook informed us that they were given information about people's dietary needs when they moved into the home and updated as and when their needs changed. They were provided with people's speech and language therapy assessment and prepared meals to the required texture such as soft mash or puree. They told us people were asked what would like to see on the menu and if they did not like what was on offer they would make them an alternative meal. We saw that people had completed surveys about the quality of food provided and had requested changes which were to be implemented. The comments and actions the provider intended to take in response to people's views were displayed in each unit of the home. However, at this inspection the changes had yet to be implemented.

People told us they had access to health care support where necessary. One person told us that staff had recently supported them to a hospital appointment. Another person told us they received support from the physiotherapists employed by the provider who had referred them to the wheelchair service for a new wheelchair. Staff told us if they found people to be unwell they reported their concerns to the nurse who arranged for the GP visit. One staff member told us they had recently arranged for a dentist to attend the home. Records we looked at confirmed this.

Inadequate

Is the service caring?

Our findings

People were not always treated with dignity and respect. One person said, "They staff don't give me a bath or a shower. I don't know why they just give me a good wash down. When they wash me I am okay if I know them or it's a girl but I am embarrassed with the men – I prefer a lady." We spoke with a relative who said they were upset because they had witnessed staff take their relative to the toilet, because they had been incontinent, and bring them back in the same wet clothing. On another occasion they told us that their relative had been left with dirty fingernails and their hands smelt. The person was eating at the time and no staff had supported the person with washing their hands prior to the meal being served.

Another relative informed us that many good staff had left and they lacked confidence in the some of the agency staff that were working at the home. They told us, "It's breaking my heart watching (staff member) feeding my [family member] as if they don't understand or feel. I don't think they [staff] have had any training in how to relate to people who have had strokes and have forms of dementia. They just do things to them it's not right." In another instance they explained how uncomfortable they had been made to feel when they had been asked to apologise to a member of staff because their relative had scratched them.

Staff told us they understood the importance of respecting people's dignity and privacy but we saw that this was not always put into practice. They told us they kept people covered up when receiving personal care and kept their doors shut. However, on the first day of our visit we observed staff taking one person from their bedroom to another room for a shower in a wheelchair. The person did not have any clothes on, staff had covered their front with loose towels but we could see that their back and sides were bare. The staff member told their manager they did not think that anyone would be able to see that the person did not have clothes on. We also saw that a number of people's bedroom doors were left open and we could see that people's skin was exposed and left uncovered.

People's mealtime experience differed across the home and was dependent on the approach of the staff member supporting them. We saw some positive interaction between staff and people as they helped them to eat their meal. However, other people were not shown the same consideration. On the Garret Anderson unit we saw a staff member support four people in turn to eat their soup. There was little to no interaction with people as the staff member supported them. The first person they served was asking where their main meal was and was told they would have to wait until everyone else was given their soup. Likewise on the Agnus Hunt unit we saw staff did not always talk to people when they were helping them. We observed that one staff member left the person they were supporting several times to complete other tasks without any explanation to the person.

People's confidentiality was not consistently maintained. On the first day of our inspection on the Agnus Hunt unit we saw a file containing food and fluid charts for people living on the unit. This was left by the telephone and was accessible to other people and visitors to the home. Although we drew this to the attention of a staff member we found the file was still in the same place on the second day of our visit. We also saw that personal information relating to people's care needs was left in public view. We found one person's personal information left on a laundry trolley in the corridor and other people's care files left on

hand rails outside their bedrooms. In one person's room their file was used to wedge the door open.

During our inspection we spent time on the Mary Powell unit. In one 45 minute period we saw 32 staff which included builders, care and maintenance staff pass through the unit without acknowledging the people sat in the lounge. In one instance a maintenance person came into the lounge turned the lights on and off twice without any consultation with the people sat in the lounge. In another occasion a maintenance person leant across a person using their wheelchair to steady themselves. They did not acknowledge or explain to the person what they were doing. We observed that the builders were carrying various building materials through the lounge and making noises that visibly startled the people sat in there. One staff member told us, "I don't know what building work is being completed where or if people living here have even been told. They (builders) just turned up. I don't know why they keep walking through the lounge when they can go round – no one seems to be managing them." It was not until we spoke with the senior management team that the builders were asked to transport materials around the outside of the home.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three people we spoke with felt they were involved in decisions about their care and were offered choice. One person told us they preferred their personal care to be provided by female care staff and this had been arranged. They told us staff were mindful of their dignity when supporting them and kept them covered up. Another person told us they would speak to care staff if they wanted changes to their care plans. However, two relatives we spoke with informed us they were not always involved in decisions or kept informed. For example, one relative told us their family member had recently had an epileptic seizure. They were on medicine to treat their epilepsy and had not had a 'seizure' for years. The relative said, "I was worried as it was a weekend that [family member] hadn't had the right tablet or that they hadn't had their medication at all. I raised it with the staff but I didn't get a proper answer and still haven't."

Four people we spoke with told us they enjoyed positive working relationships with the staff that supported them. One person told us, "The rapport between me and the carers is good." They went on to tell us they had a 'wicked' sense of humour and could have a laugh with staff. We observed positive interaction between this person and staff. Another person told us they got on well with staff. They explained that when they first moved into the home they were apprehensive about using the hoist. They said that staff provided reassurance and they now felt comfortable in using the hoist. A staff member told us it was important to get to know the person and those that were important to them. They said, "When you get to know people you get to know their relatives." They felt this helped build relationships of trust. Another staff member told us, "Everybody is an individual. I respect their individuality and personality."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that the provider had failed to ensure care and support was tailored to people's individual needs and wishes. Staff did not know or act on people's preference for care delivery. This was a breach of Regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. We asked the provider to make improvements and to send us an action plan detailing how these would be achieved. The provider told us staff would be given training on person centred approaches and care plans would be reviewed to capture people's personal experiences and preferences. We found that some improvements had been made but more were needed.

People and their relatives told us that the provider used a high rate of agency staff, some of whom were not familiar with people's needs. One person told us, "There are too many agency staff. I know they have got to have somebody but they don't know our needs. Luckily I have got a voice so I can tell them. Some people can't." Another person said, "The problem here is there are lot of contract (agency) staff. You have to keep telling them what your needs are."

People were assessed prior to moving into the home. The nurses and senior care staff were responsible for keeping their care plans and risk assessments up to date. Staff told us they liked to gather as much information as possible from people and their relatives to identify people's likes and dislikes and preferences for care delivery. This was confirmed by a relative who told us they had been fully involved in developing their family member's care plan. However, they felt this was a waste of time as staff did not follow it. They explained that they 'never had peace of mind' when they left the home as they were not confident that their family member received the care they needed. This view was echoed by another relative who had concerns about the lack of staff continuity. They told us that their family member was supported by staff who did not know them or their support needs.

Staff and management told us care plans were reviewed on a monthly basis or as people's needs necessitated. However, we found that these did not always reflect the support people required or received. One staff member told us, "I think we have just got complacent about people's plans of care. We know the people but I don't think an agency staff member would know the person they need to support if they were just to read the care plan." Another staff member informed us that nobody took notice of things that were incorrect. They told us information in care plans was copied blindly, instead of the staff member giving consideration to each person's needs. For example, they said that monthly reviews often repeated what was recorded the previous month. The management team told us they were unaware of the shortfalls in people's care plans as they had not been identified through their quality assurance processes. They agreed that they would undertake a review of each person's care plans.

Staff we spoke with told us they could find information about people's needs in their care plans and during staff handovers. We observed handover information varied from unit to unit and this meant that staff had little guidance on how to meet people's care and support needs.

People did not always receive care and support that was responsive to their needs. One person told us, "I

should be able to ring when I want something and half the time I don't get that. They (staff) tell me not to ring the bell just to take a plate away. They don't come to see what I want." They went on to tell us, "They (staff) don't give me enough time to explain what I want." We observed that staff were not always coordinated in their approach. They started tasks and then drifted off to do something else. For example, we heard a staff member ask a person sitting in a wheelchair if they wanted to be repositioned and then went on to say they would 'sort' this for them. However, the staff member did not return and the person told us they would have to go and look for other staff to help them. We saw that call bells were not always available for people in the communal areas to call for assistance when needed. This was confirmed by a person who said, "The carers, they do what they have to do but you have to shout in here to get them to come if you need something and I can't get up and do anything without help."

We looked at how people spent their time. People had different views on the level of activity and opportunities for social interaction. One person told us, "There are more activities than there used to be. They've now got an extra person on board who can drive the mini bus." Another person informed us that staff were in the process of arranging internet access for them. However, one person said, "I like it here but I wish people would talk to me I feel so lonely. Another person told us, "I am so very tired and it is so hot in here and (staff) don't bother with you much." We saw that people spent long periods of time sitting doing nothing and that much of the interaction between staff and people was instigated by the people themselves. One person told us they could not hear the television due to the other background noises. At that time we saw that there were two stereos playing as well as the television. Care staff told us they had limited opportunity to spend time with people other than when they were supporting people with personal care and meals.

At our last inspection there were two vacant staff posts to support people with their hobbies and interests. These posts had since been filled and there were now three new staff specifically employed to support people with their interests and hobbies. They told us they were working with people and their relatives to establish people's interests and how they would like to spend their time. One staff member told us they had not received training specific to activities for people living with dementia and were due to attend training to give them greater insight into this. The staff told us the provider had made resources available to facilitate activities. They said some people attended a tea dance in the local community and they were able to take people out on trips. The provider confirmed that they were investing in staff training and development in this area.

Prior to and during this inspection we received concerns from relatives that their complaints had not been appropriately responded to. We found that the provider had taken action to meet with these relatives in line with their complaints procedures. While two people we spoke with were confident to raise concerns with staff or management others were not. Two relatives we spoke with were unsure who to approach in the absence of the registered manager and with all the changes happening at the home. The provider told us, and we saw, that the complaints process was displayed at the home. We found no evidence to suggest that information from complaints was used to learn lessons from or to improve the service.

Inadequate

Is the service well-led?

Our findings

At our last three inspections the provider was rated as requires improvement. There have been breaches of regulations that required action and improvement from the provider. However, the provider has not been able to sustain improvements and a failure to recruit and retain staff coupled with ineffective leadership has meant people's experience of living in this home has been poor. At this inspection we have identified multiple breaches of regulation that the provider will need to address.

The registered manager was away from work at the time of our inspection, we learnt that they had resigned shortly after. The provider had arranged management cover for the home in their absence. Senior managers were supporting the service and were present during our visit. Without a registered manager the provider is in breach of a condition of their registration.

The ineffective leadership in the home resulted in a lack of confidence in the registered manager and how the home was run. One person told us, "[Registered manager's name] is invisible I would not rate them. I like [deputy manager's name] I respect them. They are the foundation of this place." Another person said, "It has an effect on me. I'm worried what's going to happen here." A relative said, "I don't think the care is good here currently and I wouldn't recommend this place to anyone. It runs on skeleton staff at weekends, that's when things happen. Shouldn't the standard of care be consistent throughout the week?"

There was a lack of openness and transparency in the service. People and their relatives told us they were not always kept informed about incidents involving people. They also felt that concerns they raised with staff were not responded to in an open and honest manner. We saw that safeguarding and whistleblowing information was prominently displayed on notice boards in each unit of the home. The provider had submitted notifications of allegations of abuse at the home. However, we found that they had not always been open and transparent when informing family of such incidents. For example, one relative told us their relative had been involved in an accident where a staff member had caught their family member's toe on the footplate of their wheelchair. It was not until some months later when they were sent an investigation report completed by the provider they found out the full extent of the incident which related to alleged abuse of their relative by a staff member. In a further instance a staff member we spoke with told us they had reported a concern to the registered manager. However, it was not until another staff member reported the same concerns two weeks later that action was taken.

Staff felt the registered manager was not always approachable. One staff member told us, "Sometimes [Registered manager's name] was quite rude and abrupt. Staff don't mind being told when they are wrong it was just their manner. It got to a point I didn't want to come to work." Another staff member said, "I'd knock on their (registered manager's) door and they would say, not now I'm busy. This puts you off going to them again and leaves you feeling stressed and feel like not coming to work." Three staff we spoke with told us they lacked confidence and trust in the registered manager. One staff member explained when they used the whistleblowing policy to report concerns about staff practice and the next day other staff knew about it. Another staff member told us that their confidence had been broken and other staff had been informed about their personal circumstances. The staff member had been told to enter their concerns on the 'quality

of life' systems which they did but no action was taken to address this. The provider said they encouraged people, their relatives, visitors to the home and staff to enter their views on the 'quality of life' electronic tablet. The provider's 'quality of life' system collated information about the quality of the service. We spoke to the senior management team about how they monitored concerns raised on the 'quality of life' system. They told us and showed us there was a section for management oversight. However, they found that concerns had not always responded to by the registered manager. This led to a lack of oversight of the concerns that staff were raising in the home.

There were staff vacancies at the home and staff morale was low. One staff member said, "Staff morale is at rock bottom because of all the problems. It is affecting staff very much." Another staff member told us the current situation made them feel insecure. They went on to say, "Many staff are leaving because they are very unsettled." The senior managers told us they were 'continually' recruiting, they could not tell us why staff could not be retained once recruited.

Staff felt there was a lack of structure and no clear direction. One staff member informed us there were too many managers and not enough care staff. They said, "Different people telling us to do different things." Another staff member told us, "I'm not very impressed. Very disappointed with them (management team). We don't know what is happening about anything. Things are always changing – every week there is something new. We never know when we come in what we are coming in to." Staff told us there was a lack of communication in regards to new staffing and the building works at the home. One staff member said, "A new maintenance staff member just started coming in we were not told who they were. They don't wear a uniform of ID and they could have been anyone. Don't feel able to challenge them about what they do and I don't know who their manager is."

We found that there was a lack of leadership and a complacent working culture at the home. Staff were not always clear on their roles and responsibilities and had failed to deliver effective care to people. The management team told us that they completed walk rounds at regular intervals throughout the day. This allowed them to monitor staff practice and provide support where necessary. Despite the checks in place they had failed to identify the areas for improvement we found and the deficits in staff practice that we had highlighted during our inspection. This included staff's failure to protect people's dignity and to maintain a safe environment for people.

We found the quality assurance systems the provider had in place to assess and monitor the quality of care were not always effective in identifying or driving improvements in the service. For example, we looked at one care record which recorded a person as being 'bed bound' since 2015 and only being able to 'tolerate short periods in a reclining chair'. However, we found that this person was sat in a wheelchair in a communal area for most of the day. We saw that this person's care plan was reviewed on a monthly basis and recorded no changes in the person's needs on each check. When we spoke with the senior managers we found that the person's care records had been audited on 15 March 2017. The audit asked if the care plan reflected the person's' needs and had recorded that they did. The senior manager was unable to establish who had conducted the audit because the audit tool did not gather this information. They went on to tell us that a new registered manager 'tracker' system had been introduced in March 2017. The purpose of the tracker was ensure that actions identified in audits or through feedback from people, relatives and staff were responded to and followed through. We were unable to establish the effectiveness of this system at this inspection as it had only just been introduced. The senior manager's told us that they provided feedback through the various meetings with people, relatives and staff.

Staff we spoke with did not feel involved in the development of the service. Staff told us there had been lots of changes in the home and senior management had held meetings to discuss these. However, staff found

that staff meetings were not effective. One staff member told us, "Same things get said all the time. I feel like I'm wasting my breath." Another staff member told us they did not feel that they would be listened to even if they did make a suggestion about how to improve things. Staff informed us they were not always consulted on what they needed. For example, one staff member explained they had been given new laundry trolleys to improve infection control. These trolleys had 12 drawers for 19 people. The staff member said, "We were not asked about the trolleys and they are not practical for some people's laundry as some people like to wear sweatshirts and these will not fit in the drawers."

Staff did not always feel supported in their roles. One staff member told us, "It feels very isolating here. It is not a team when it comes to responsibility. If something goes wrong then it is up to you." Another staff member said, "At the moment is seems like there is a lot of 'faffing about' instead of pulling together." Staff on the Garrett Anderson unit told us they did not feel the provider gave them the equipment they required to do their job well. For example, they had recently run out of caps for the thermometers and were unable to take people's temperature for two weeks. A nurse told us they were with a GP who wanted to take blood but there was not one syringe in the unit. There was no camera available on the unit to assist the monitoring of wound care and staff had to go to another unit to get one. They explained that it was difficult to maintain people's compliance with care if they did not have the required equipment to hand when they needed it. They also told us the current blood pressure monitoring tool they had was not suitable for people who presented with challenging behaviour. They had asked for a more suitable tool but this had not yet been provided. The senior managers told us they were keen to make the required improvements to the service and had committed additional resource to the service to enable them to do so. They recognised that the culture within the service needed to change to drive forward the vision for the service and achieve better care for people.

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

Staff we spoke with felt the senior managers who were currently at the home were approachable. One staff member said, "The last couple weeks things have been better. More Four Seasons hierarchy are here, things are getting done. These are changes we have wanted doing for a long time. The atmosphere is happy and livelier. Another staff member told us, "The [senior managers] we have got now are very helpful, they do listen. It's nice to feel you have someone that you can go to." All the staff we talked with spoke highly of the deputy manager and felt that they could rely upon them. One staff member told us, "The deputy is the backbone of this place. [Deputy manager] is everybody's mum. If they went this place would fall apart. Another staff member said, "[Deputy manager's name] will bend over backwards, if it was not for them the home would shut down."

The provider had submitted statutory notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events and changes at the service without delay. This allows us to monitor any trends within the service.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people's privacy and dignity were maintained.

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 always received safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not followed the principles of the Mental Capacity Act and people were unlawfully deprived of their liberty.

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 provider did not ensure effective governance to drive improvements in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured enough suitably

Diagnostic and screening procedures

Treatment of disease, disorder or injury

trained staff were effectively deployed to meet people's needs in a timely manner.