Bupa Care Homes (CFHCare) Limited

Anglesea Heights Nursing Home

Inspection report

Anglesea Road
Ipswich
Suffolk
IP1 3NG

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 1 and 2 June 2016. This was to follow up on the previous comprehensive inspection on 5 and 19 November 2015 where we had identified seven breaches in regulation and had placed this service in to special measures. At this inspection we found improvements and the safety of people at this service has improved. We have seen a reduction in breaches in regulation and have reported on three breaches ongoing. CQC had placed three positive conditions on the registration of Anglesea Heights. We found that two conditions relating to management and nursing were being complied with. There were further improvements to be made to comply with the condition relating to medicines management. However, due to an administration error at CQC, this condition had not been correctly applied. This condition is now in place and going forward we will continue to monitor the compliance with these positive conditions to ensure people are safe at this service.

Anglesea Heights Nursing Home is a care home with 120 beds divided into four separate buildings with 30 beds in each building: Alexandra House, Gippswyck House, Christchurch House and Bourne House. Each house provides nursing care. At the time of our inspection Bourne House was due to close the next day and people who had resided there had moved into other parts of the service or to different care homes that could meet their needs. There were 68 people resident.

This service requires a registered manager. A new manager had been appointed and had been at the service for five weeks on the day of our visit. They had applied to be registered. 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.

At this inspection of the service we found matters had improved from our last visit but still needed to develop further. We were not assured of consistency in terms of staffing being appropriately trained and deployed. We found people in need of support and unable to summon assistance. We were also concerned that agency nurses were used in large numbers particularly at night and did not know people they were caring for. The number of care staff had increased as had their training in dementia care.

We observed some very caring interactions between people living at the service and staff. Staff were warm in their interactions, communicated well. Some helped out with shopping for people and planted flowers for people to enjoy. Relatives had seen improvements and expressed their views positively with us. People had prompt access to healthcare professionals and relatives were pleased that changes in people's wellbeing was communicated well. Care and support was effective on the whole, but there were inconsistencies in approach. We found that not all changes in a person's care was communicated effectively and may have been slow to have been responded to except for our intervention on the day. Examples included a person who had developed a sore heel, a person feeling cold and call bells to summon staff being out of reach, also some people were at risk of dehydration as they were not monitored effectively.

People generally enjoyed access to a varied choice of foods and said how this had improved. Some people said how they enjoyed the variety of activities and choices of how to spend their day. Some people living with dementia did not have such a positive experience.

Since the last inspection a new management team has been put in place. Systems of evaluation and auditing have begun, but needed time to embed. Unit managers had their already limited time to manage compromised due to being drawn into leading nursing shifts because of the high usage of agency nurses.

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. There were at times insufficient numbers of skilled and experienced staff deployed to meet people's needs.

Staff had a good understanding of how to recognise and report any signs of abuse, but staff did not act consistently and appropriately to protect people.

Risks had been identified but were not always consistently managed appropriately. Assessments had been carried out in line with individual needs of people.

People's medicine management was not robust.

The service was clean and hygienic.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did have induction training and access to on going training, but the clinical skill level of the nursing team was not comprehensive enough to meet the needs of all people at the service.

Staff had received appropriate training in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards. Staff displayed a good understanding of the requirements of the act, which had been followed in practice.

People were supported to maintain a healthy diet, but people at risk of dehydration were not consistently monitored.

People had timely access to healthcare.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Positive, caring relationships had been formed between people and staff.

People were involved in decisions about their care and support and were kept informed about the running of the service.

Most people were looked after by staff that treated them with kindness and respect, but consistency of kind compassionate care was not always achieved.

People were supported by staff that respected their dignity and maintained their privacy. End of life wishes were not always appropriately recorded.

Is the service responsive?

Requires Improvement

The service was inconsistently responsive.

We found pockets of good practice where people had been listened to, involved and had an individualised service that met their needs, but this was not consistent.

Care records were in the main personalised and so met people's individual needs. But not all changing needs were effectively communicated in a timely way.

Some activities were meaningful and were planned in line with people's interests, but some people were unstimulated.

People's complaints were taken seriously. People felt listened to. People's experiences were taken into account to drive improvements to the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The management team were all new, their roles were defined by a clear structure.

Unit managers had limited time to manage their units and high agency nurse usage made personalised care a challenge.

Positive conditions imposed by CQC were being worked towards and we will continue to monitor compliance.

The new manager has set up systems to monitor and evaluate the service, but as yet needs time to complete and embed these systems.

Anglesea Heights 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.

This inspection took place on 1 and 2 June 2016 and was unannounced.

The membership of the inspection team consisted of two inspectors, a pharmacy inspector and included an expert-by-experience and specialist adviser. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had expertise in older peoples care. Our specialist was from dementia care.

Information was gathered and reviewed before the inspection. This included all the information we held about this provider, including statutory notifications. These are events that the care home is required by law to tell us about.

The methods that were used included talking to six people using the service, seven of their relatives and friends, speaking with 13 staff, pathway tracking 10 people using the service, examined 13 medication administration records, observation of care and the lunchtime experience. We also looked at and reviewed records relating to medicines management, recruitment, training, audits and management of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in November 2015 we had serious concerns about how medicines were managed. At this inspection we found that improvements had been made, We found that medicines were stored securely. However, in Bourne House where there were only two people staying on day one of our inspection, medicine storage procedures weren't followed consistently. The controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) had not been checked regularly as they belonged to people who had moved to other homes and staff had forgotten they were there. Staff destroyed the medicines as soon as we brought it to their attention. The fridge temperature had not been recorded since March 2016. Although there were no regular medicines stored in it, one person had been prescribed an antibiotic liquid and some eye drops so it still needed to be maintained at the correct temperature.

We looked at records for 13 out of 63 people and found that, in general, medicines administration was clearly recorded. Records showed that staff gave warfarin, a medicine which is adjusted regularly in line with blood test results, to one person as prescribed. However, records of medicines received, used and disposed of did not provide a full audit trail and did not allow all medicines to be accounted for. Staff did not always record the dose given when instructed to give one or two tablets, and did not always complete the record of stock remaining at the end of each day in line with the policy.

There were protocols in place to guide staff on when to administer medicines intended to be given when needed, for example for pain or anxiety, and in some cases we saw they were used in conjunction with pain assessment tools. However these were not used consistently and one person who said they were in pain when they were moved did not have a protocol in place for their pain relief and it was not always given before they were moved.

Since our last visit the number of people given their medicine covertly, disguised in food or drink, had reduced. We found two people who were given medicines hidden in their food, and both had a plan in place showing that the appropriate people had been involved in the decision and that this approach was in the person's best interest. The pharmacist had advised on whether tablets could safely be crushed and hidden in food.

We saw records to show that the clinical manager regularly audited medicines management processes in each of the houses, and staff told us that they knew the outcome of those audits. However we did not see action plans being developed from these audits in order to drive improvements in the care of people. This is an on going breach of the Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in November 2015 we had concerns that people were not as safe as they should have been. We found that safeguarding referrals at that time suggested that matters had gone unreported and not actioned, this had been happening in the past and for some time. This indicated that there was not a culture of openness and transparency with vulnerable people's needs and safety not being the top priority.

At this inspection we found matters had progressed. People at the service told us that they felt safe. One person said, "I feel safe, the carers make me feel safe and I sit and talk with the male carer, he is a lovely guy". Another person told us, "I have never had anything taken [I keep money in here] I do trust them". Relatives we spoke with also said that they felt that people were kept safe. One relative said, "Yes [my relative] is safe as when staff see that resident need something they are there straight away – they are safe". They went on to say, "Since the staff not getting a good report here, they are trying to do better and keep their eyes open more to be more protective". A different relative said, "I have not heard staff shout or be unkind".

We found inconsistencies in relation to keeping people safe from avoidable harm and abuse. We spoke with staff, some of whom had a good understanding of how people needed to be protected. Staff confirmed that they had received training and were up to date on safeguarding people from abuse. Some staff clearly understood situations that could constitute a safeguarding issue (e.g. unexplained bruise or changes in behaviour) and how to report concerns, even when they related to their direct line manager. We observed lunchtime and saw one member of staff was forcing a person's arm down whilst supporting them to eat their midday meal. We cross referenced what we saw in the person's care plan with guidance for staff in relation to best interest assessment and the use of this restraint. We found no guidance written to require staff to act in this way. We met a person in bed in Christchurch House. They were in bed with bedsides up to keep them safe. However, they did not have a drink within reach. The call bell was on the wall out of reach. They told us, "I am cold". We were required to summon a member of staff to assist and they went and got a blanket and very carefully placed this over the person.

There was a lack of access to call bells in communal areas and no evidence of pendant alarms in use. For people in their rooms, there was no evidence that easy access to call bells had been provided. Call bells were not consistently in easy reach for people. In Alexander four call bells were out of reach. Observed practice of staff and insufficient means to call staff placed people at potential harm.

Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. Managers had appropriately reported matters that they had become aware of and were working with local authorities to ensure people were safe. We saw evidence that safe recruitment procedures were in place to ensure that people received safe care and treatment from staff who had been suitably checked for their identity, work history and references and for Disclosure and Barring Service checks. This showed the manager took measures to recruit appropriate staff. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service.

At our previous inspection in November 2015 we had concerns about staffing levels and the high usage of agency staff including agency nurses who did not know the needs of people in their care. At this inspection matters had improved. However there was still a high usage of agency nurses especially for night shifts. One relative said, "The only time there is not enough staff is weekends but since the last inspection they do have more staff on and far less agency staff – the staff know the residents likes and preferences and I like to see it". A different relative told us, "It has been very good, they struggle with staffing and since the last inspection staffing has improved a bit but there are still troubles like covering the day room when people need the toilet. But it is better than it was – they are not unsafe – sooner or later a member of staff would be available". They went on to say, "There is a high turnover of staff, but I have no complaints about the staff". On Alexandra we spoke to a person who lived there and they told us their experience of, "…waiting 15 minutes for the toilet when ringing the buzzer". They spoke of the staff being busier since the intake of new residents from the closure of Bourne House, saying, "Mostly they needed two carers". A different person told us. "Longest wait is 15 minutes – worst in the evenings. They are so busy and I get frustrated at having to wait".

We also observed staffing on Alexandra House. We saw a person sat in bed with their meal in front of them and they needed assistance. They became distressed calling out, "My leg, my leg, help me with my leg". No staff came. After 12 minutes we went and found the nurse who said, "She refused to get up today, normally she is in the lounge and has her dinner there and we keep an eye on her. We have two assisting on this side". After a further 15 minutes a carer brought the desert and together they repositioned the person who then ate their desert. The main course was cold by then and no alternative was offered. The carer did come back after five minutes to check this person was eating their desert. On Alexandra we did see good practice from a staff member informing another staff member that they were leaving the main lounge area and therefore needed them to replace them which happened. This communication ensured staffing was available and visible to support a group of people in the lounge areas at all times.

Staff told us that there had been improvement in the number of care staff available. New staff had been recruited. One member of staff said, "It is much better now that we have more staff. We are less rushed, less stressed and have more time for people."

We saw in people's care planning that dependency levels were assessed and reviewed to inform the manager about needs of people to help determine staffing numbers. We examined the rosters for two weeks before and after our inspection. This showed the high usage of agency nurses especially at nights. There had been recruitment of care staff and this showed in the increased number of care staff deployed. Rosters generally showed consistency of staff deployed, but two shifts on Alexandra dropped to five care staff on a Sunday morning on two occasions. There should have had a minimum of six and sometimes have seven. On Christchurch House the roster showed that on five occasions in the four week period, they dropped to five care staff on shift when they usually had six or seven staff on shift, but on 10 occasions there were nine or eight care staff on shift. The staffing roster on Gippeswyk House was more consistent with seven staff in a morning and six staff in an afternoon. We concluded that on balance the staffing had improved with less incidences of concern noted at this inspection than the last, but that risk was still apparent as staff were not consistently deployed when and where they were needed. We were aware that Bourne House was due to close in the next day or so and this would provide additional care staff to be deployed onto the other houses.

At our last inspection we had concerns about the cleanliness of the environment. At this inspection we found that this had improved. There were sufficient housekeeping staff employed to maintain a clean and fresh environment. A relative said, "The cleaning now seems to be a lot more visible since your last inspection and I see them around doing a lot more cleaning".

There was a variety of risk assessments produced. For example, in relation to moving and handling of people. These had evidence of regular review. We asked people about their experience of using a hoist. "The hoisting is alright provided they put the sling on right under me and I let them know if they have not done it right – they do it alright". Another person said. "No problems it is done efficiently".

We also saw risk assessments in relation to the use of bed rails and risks associated with eating and drinking. One person who had been assessed as at high risk of falls was wearing slippers but the soles were loose and flapping. We pointed this out to staff who told us they had noticed that this person's inadequate footwear presented a trip hazard. In addition we left this point as written feedback on the day of our visit with the manager to rectify immediately.

Records showed us that risks relating to the environment were regularly assessed and maintenance and servicing records were up to date.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we had concerns about staff skills, knowledge and their support and supervision. At this inspection there was progress. One nurse we spoke with said they had the skill and training to work with people living with dementia. A member of care staff said, they had completed a lot of training including 'part one' of her dementia training which she found helpful in terms of understanding types of dementia and which part of the brain was affected. She was looking forward to completing part two. This information tied in with what managers told us about 75% of staff having completing their 'Person First Dementia Second' training. There were now were eight staff designated as dementia champions. We also spoke to a staff member who was quite new. They confirmed they had completed four days training that covered matters of health and safety such as food hygiene, fire safety and moving and handling people. They had also been taught how to support a person to eat. They said they had regular supervision and that their manager was approachable. "I love it here. I can always ask the other staff", they told us. We spoke with a nurse who said that they keep up to date through accessing national best practice but that their regular supervision allows them to request any clinical updates they need. Records showed that nurses had recently attended training on pressure ulcer prevention and management and nutrition risk assessment training. We also saw that nurses had their medicines training updated and had been observed as being competent.

At the last inspection we reported: 'Only one nurse in this large service had up to date skills to set up and use a syringe driver [This is a direct way to deliver pain relief at the end of a person's life] Only two nurses had completed training in catheterisation of people. Only four nurses had successfully completed venepuncture training [collection of blood from a vein]'. At this inspection we were unable to assure ourselves that the nurses as a team held the appropriate skills and knowledge to meet the clinical needs of people residing in this nursing home. Each nurse did have a personal development plan being developed. However, we found that objectives were generic stating 'complete revalidation and undergo training for continual professional development'. We did not obtain evidence to show that nurses had the skill set to manage clinical issues as they arose. On balance the number of people nurses had to support had declined due to the closure of Bourne House and a clinical lead nurse had been recruited, but there had not been a program of increasing the clinical deficit skill of nurses since our last inspection. Therefore this is an on going breach of the Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in November 2015 we had concerns relating to consent, care and treatment. We found that people had their liberty and freedom of movement restricted by use of box chairs that meant a person could not stand and all bedroom doors on Bourne House were locked. At this inspection we found matters had improved. The manager had a good understanding of both the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) and when these should be applied to the people who lived in the service, including how to consider their capacity to make decisions. 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 are called the Deprivation of Liberty Safeguards (DoLS). The manager had completed another three applications for DoLs referrals in April 2016 to the local authority in accordance with new guidance. Staff informed us that they had completed training in relation to MCA and DoLS.

In one house we spoke with the nurse on duty. Following their quick review of three care plans, they were able to promptly answer queries that were raised in relation to decision making and DOLs. We reviewed the records. The information was up to date. There was evidence of MCA assessments, DOLS applications, Lasting Power of Attorney documentation and Best Interest decision making and discussions with family members as appropriate. We examined records in other houses and found them to be accurate and up to date. In the office on Christchurch information about people's DoLS status was to hand and visible to staff. Where two people had gates across their room doors, DoLS authorisations had been submitted and we saw good evidence of seeking views of relatives with best interest decisions considered. On Gippeswyk House we were informed that a gate on a person's door was being removed and was to be replaced with the least restrictive option of a sensor mat to alert staff to the person moving about.

We spoke with one person on Alexandra House. They told us that they had hearing problems and did not always catch what was said to them. "They treat me as if I have dementia. I haven't". Staff we spoke with told us they knew the person did not live with dementia. However, this may not have consistently been the approach because this person's hearing loss was not accurately documented in their care plan.

At the last inspection in November 2015 we had concerns about the people's eating and drinking and maintaining a balanced diet. At this inspection we saw improvements. One relative said, "It is improving all the time, the tables are now laid nicely". A person living at the service told us, "I eat where I like, either here in my room or in the dining room. The food is very nice". A different person said, "Very nice here, the food is wonderful and the staff are fine".

In Alexandra House we observed some good practice of staff interaction. We heard staff say, "Do you want a napkin on to keep you tidy?" The staff member gained consent before placing over the person. Staff offered choices such as, "Do you want beef cobbler or would you like gammon?"

In Christchurch House people were asked what they wanted for lunch during the morning. Some people were offered a visual choice at the time of serving lunch. One person declined lunch and staff sensitively, repeated the offer of both the main meal and desert throughout the lunch service. The person was gently persuaded and agreed to drink a glass of orange and a cup of tea instead. Another example of good support for a person to eat well was observed during lunch time. A care worker was sat close enough to enable her to observe the small signs of non-verbal communication from the person to ensure that they ate their meal at a relaxed pace. Although the care worker's focus was on the person, she was able to appropriately respond to a person sitting behind her who began to cough. The staff member acted appropriately as they knew this person was at risk of choking. (The person had finished being supported to eat a little while earlier)

We found the daily menu choices indicated there was a range of cooked and cold foods available throughout the day and night. Hot and cold drinks were made available to people at set times, there was little evidence of cold drinks being available throughout the day, for example not being within reach on side tables in the lounge area, and out of reach in some bedrooms. Although there was a water cooler in the lounge areas for those able to access it.

On Gippeswyk we found records used to calculate people's daily intake of fluid to be inconsistent. We found

many gaps in these records which had not been picked up in any clinical audits. There was no guidance as to the amount of fluid that should be consumed within a 24 hour period for people to be sufficiently hydrated. When we asked care staff if they knew how much fluid should be consumed they told us they did not know. Where fluid intake was way below the recommended daily intake we noted insufficient evidence that any action had been taken in response. We observed very few people to have access to drinks throughout the day. There was a lack of tables available for people help themselves to drinks. We did find that people's weights had been monitored and referrals to dieticians where appropriate.

At our last inspection we found concerns with people not getting appropriate and timely access to health professionals. At this inspection we found improvements had been made. One person told us, "I regularly see a doctor and a chiropodist". Another said, "See the GP, dentist, Chiropodist and hospital appointments - they took me when I went last year". The same person went on to say, "Last week I had a shingles jab after getting a letter from the doctor and the nurse gave it to me and every little while they came to check on me and even in the night the nurse came to check on me".

There was evidence in care files of people being referred to the GP and other healthcare services as appropriate. A member of care staff told us there was always a nurse on duty and she would report any concerns she had about observed changes in people's behaviour. E.g. choking, looking pale, to the nurse. Relatives said that they were kept well informed of people's health conditions and changes that occurred. "They are very good at informing me, for instance my relative recently had a [medical concern] and they told me that they had called the doctor. I knew everything". Another relative said, "They phone to tell me of changes to his meds, if he is poorly and tell me of his general wellbeing". A different relative told us, "I am more confident in their care now and a lot happier. The communication was not good on Bourne House but they tell me now of any incidents and if the doctor has been. I am a lot happier now, if I cannot get in it does not worry me as I know that they are being looked after".

Requires Improvement

Is the service caring?

Our findings

In our last inspection report we said that people's experience depended upon where people lived within this large service. Also that relative's feedback was varied. At this inspection we found that Bourne House where we had the majority of our concerns had all but closed and there was a much more consistent caring approach across the three remaining houses.

Majority of staff were observed engaging with people in a way that was warm, caring, kind, inclusive and respectful. Specific examples included a staff member saying clearly to a person, "Morning Sir, how are you?" Another staff member said, "I'm going to make hot chocolate, would you like one". This was followed by a discussion about how they like their hot chocolate. We also observed one person was offered lunch but declined, then offered a cold drink and accepted. Later they were offered lunch again but declined, so staff offered a cup of tea and they accepted. The person drank both drinks. We found staff remained visibly concerned about this person and regularly checked in with them, responding to them appropriately by respecting their decisions and choices whilst offering encouragement.

Relatives gave positive feedback. "Staff are very helpful, one of the nurses went shopping for my relative and brought them the new clothing that they needed. They do that to help out". A different relative said. "I am happy with the carers they are very helpful. The staff are very motherly. I have seen them kissing residents sometimes. I see them stopping when they have a moment to chat to them. I feel quite happy to leave and know that they are there. My relative cannot do anything for themselves".

Consistency was lacking as evidence suggests staff were certainly caring in their approach and there has been significant improvements, but some of the evidence in other key qeuestions suggests that some people are not receiving a truly caring service form this provider.

On Christchurch House we saw that staff had a flexible approach to times people got up in the morning respecting individual's preferences. We saw a person getting up, still wearing their night clothes. A staff member immediately responded to them saying, "Are you OK [named the person], did you have a nice sleep? You had a lay in today". This showed kindness and good knowledge of this person's routine. One person on Gippeswyk House explained to us how staff were kind to them. "The majority [of the staff] go out of their way for you. Yesterday I did not want the sweet at lunch and one of the carers brought me some of her fresh peaches, she had peeled them, that meant allot." They went on to say, "Sometimes I ask the girls [staff] to do some shopping for me. They get cereals, OXO and biscuits".

One relative said how staff knew [their] relative well and how respectful they were. "Very attentive staff, they know [their] needs and they are very good with [them]. Staff do talk to [them] and stand closed up as [they do] not see well". We observed staff treating people with dignity and respect and staff were discreet when supporting people with their personal care needs. For example, we saw staff knocked on people's doors and waited for a response before entering. Staff were sensitive to people's needs, not rushed and supported people in a dignified manner.

People's end of life wishes could be better understood and recorded. We reviewed how the provider sought the views of people and those important to them in planning for their end of life wishes and preferences. Where a decision had been taken to not resuscitate a person in cardiac arrest (DNACPR), we found this had been clearly and appropriately decided and documented. The majority of people had these notices in place. Some of these had been produced whilst the person was previously in hospital and had not been reviewed in this new location as should have been. This information was highlighted in a person's file by being placed in a yellow plastic wallet that sat in the front page pocket of the care plan folder so it was obvious which person had one. Thinking ahead forms used to record people's advanced care planning were inconsistently completed.

There were opportunities for people to express their views and be listened to. There was a regular system in place for reviews of people's care called 'Resident of the day'. However, this was not consistently implemented across the houses as per BUPA guidance. Because some care plans were reviewed in the main by nursing staff alone.

The manager conducted a daily walk around of all the houses and said that they were visible to people and that they actively asked people about their experiences during that time. In addition there were regular resident and relative meetings conducted. This was used as an opportunity to receive suggestions on improving the service on offer. One family member on leaving following lunch said to us, "It all works here, nothing wrong with it". A person living at the service explained, "Resident's meetings, we talk and discuss food and they always ask what activities we would like to do". A different person said, "Resident meetings are once a month. We said the meals were not always hot and now they are hotter since we said at the meeting". A relative told us, "Relative meetings there was one two or three weeks ago. I go to all of them. They are very useful and it allows residents and relatives to put forward points. Normally there is an improvement made after a complaint".

Two family members were offered lunch, after people residing had received theirs. Staff were observed to be friendly and warm in their interactions with family members who were visiting the house, and the family members appeared to be at ease and able to come and go as they pleased. Another relative said, "Visits - I can come anytime".

Requires Improvement

Is the service responsive?

Our findings

We found inconsistencies in how people received care support. Care support was not always personalised and responsive to need. One agency nurse referred to people on several occasions by their room number and not their name. Two agency nurses did not know the names of all the people they were supporting when we requested this information.

We looked at the records of one person's care from the previous evening. The night staff had recorded their observation of a large black mark to the skin on the heel in this person's daily notes. This indicated a possible pressure ulcer developing. Staff also recorded that they had passed this information onto the agency nurses for that day to take action. No body map had been completed. We noted from a review of handover notes this had not been recorded as an area for nursing staff to action. Agency nurses said they did not know about this until we had communicated our concern as to the lack of action taken and pointed this out to them. Therefore, we were concerned as to the lack of responsiveness in this case until our intervention.

The same person had deep wounds to their legs from bilateral leg ulcers. Staff had recorded within their daily notes that they appeared to be in pain when repositioned in bed. However, we noted that no action had been taken forward to address this and ensure that pain relief was sufficient prior to any such manoeuvre. Our pharmacy inspector checked to see if there was a pain management plan in place to guide staff in ensuring that sufficient pain relief was administered before any changes of dressings to their wounds. We found that there was none in place. This had the potential to put this person at risk of not receiving sufficient pain relief as and when they required. We fed this back to manager at the end of day one and on day two were given assurances that this was in place for the person. However, we remained concerned as to the responsiveness of nursing staff in this case until our intervention. This is a breach of the Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found conflicting information in people's care plans with regards to the regularity of repositioning them to protect people from the risk of pressure ulcers developing. For example, one person had recorded in various parts of their care records anything from two hours to four hours. This meant that staff did not have consistent information to guide them in protecting people from the risk of harm. We also observed that people sat in wheelchairs for long periods without being transferred to other comfortable seating. Whilst some people had pressure relieving seat cushions others did not. Sitting for long periods of time presented a risk to people's skin integrity and nursing staff had not ensured individualised responsive care was in place for all people.

In other care plans we found them to be up to date with regular legible entries made (including daily notes) that talked about the person's mood and behaviour as well as any physical issues. Throughout the care plans the use of positive language and the absence of negative value based language was evident. The assessments in the care plans fed into the plans developed for staff to follow.

Care plans detailed what activities people had been engaged in, but were not based upon any personalised

care planning that attended to the emotional and psychological needs of people. None of the care plans we tracked contained a care plan that adequately demonstrated how the service responded to individual's differing care needs in terms of pervious or known interests, social activities, types of dementia or stage of dementia. We saw no signage to aid those living with dementia and no sensory items for people to pick up or focus their minds and imagination with. On Gippeswyk we made the observation that some people remained unstimulated, some appeared bored, some people paced from room to room and others sat sleeping for the majority of the day. Where as in other parts of the service we saw activity staff that had an approach that was warm, well-paced, genuine and caring. We observed a hand massage. It was a nice one to one interaction of sitting and chatting. Later the activities person had a book of historic photos of the town. Even though the person could not speak they were smiling and looking animated. In Alexandra House we saw two ladies having their hair done, with positive interaction with the visiting hairdresser. One person told us, "The activity girl came last week on her day off and planted all those baskets outside my room".

The feedback we received from people not living with dementia was positive with regards the activities. One person said, "We have the Hub ladies afternoons. They dress us up in hats, beads and the staff dress up too, we have afternoon tea. We had an Avon business come and we tried all the bits, and had our make-up done. We did decorating fairy cakes. The activities are interesting, what with a curling afternoon, fun fare afternoon and choir occasionally". A different person said, "You do what you want, on Wednesday I go to the MS club in the town. The activities are brilliant and [named staff] does nails. We have one to one time and we usually just sit and talk and I like that". A relative told us, "Activities are very good. There is a list of the entertainment on the wall (Christchurch House), they take residents and relatives to Felixstowe for the day in the summer. The residents can go to the other houses for their entertainments, but I do know of residents from here that go".

People told us that they could raise concerns and felt that they were listened to. One relative said, "I have no complaints". There were formal systems in place for recording and responding to concerns. We saw that appropriate actions had been taken as a result of a complaint to lessen the possibility of an occurrence. Managers explained that in the recent closure of Bourne House they had written to everyone involved and had kept people informed. 40 people attended a planned meeting about the closure to ensure as many people were informed as possible. Managers felt communication had been good during that time and no complaints had been received during the process. Matters that were raised were dealt with.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2015 we had serious concerns about the management structure and the availability of nurses within this service. Since that time there has been change within the management structure within this service and a 'recovery team' were brought in by BUPA to enable this service to come up to standard. There was a manager in place [they had been at the service five weeks at the time of our visit] and they were in the process of applying to become registered. They were supported at the service by a clinical services manager who was new and a deputy manager who was due to start in two weeks' time. Each of the units had a manager. One staff member said, "The new management team visit the homes more often and all the staff are really pleased about this".

Relatives spoke of improvements since the last inspection on matters such as cleanliness. "Since the last inspection cross contamination improvements have been made and we have these coloured bins on the trolley and they have got more cleaning equipment likes sprays. The biggest difference is that it smells cleaner". A different relative said, "I think it is a good home. I'm not sure who the unit manager is but I have been introduced and if I had a problem I would go first to the sister in charge and I can go and see the people in the office". Another relative told us how they believed the service had improved for them since the closure of Bourne House. "When I leave [my relative] here I have no worries but when I left [them] in Bourne I was a mess and worried all night". Relatives also said that the transition from Bourne House was managed well.

We still had concerns about some management issues within this service. Firstly, unit managers had only six hours a week to complete all staff supervision, complete audits of matters such as care plans and devise rotas. These unit managers were nurses and told us they often lost these hours due to the need to cover vacant nursing shifts. Our second concern was the constant use of agency nurses. This was not helpful in ensuring consistency of care, effective communication of information to protect the health, welfare and safety of people. We observed a handover meeting and saw that agency nurses did not know the people very well. We found that the communication sheet introduced on in Alexandra House was working well, but in other houses there was need for improved communication from shift to shift. Since our inspection we were notified that two regular nurses had been suspended from duty and replaced by agency nurses.

At the inspection in November 2016 we had a number of concerns that have been progressed, but we took the step to place positive conditions upon the service to ensure action was taken. This related to having qualified nurses on shift at all times [we believe this had been complied with due to the use of agency usage], having a clear management structure in place [we believe this was being complied with as described in the above paragraph] and finally for BUPA to send us, the Commission, each month a copy of medicines audits to show that people received medicines as intended by the prescriber. If there were any discrepancies found we wanted to know the action taken to keep people safe. At this inspection we found that this positive condition had not been complied with. However, due to an administration error at CQC, this condition had not been correctly applied. This condition is now in place and going forward we will continue to monitor the compliance with these positive conditions to ensure people are safe at this service.

We found that the managers at the service had been working well with external professionals. The local Clinical Commissioning Group [CCG] had sent in a pharmacist and they had worked with the service and a local GP to reduce the amount of covert medicines in use at the service. The supplying pharmacy had changed and for two months nurses at the service were being supported and coached by professionals at the pharmacy to ensure ordering and procedures were correct. Managers at the service had also cooperated with local authority professionals in reassessing and the placing of people from Bourne House. In addition managers at the service were working with the local safeguarding officers who were at the service looking in to a number of safeguarding matters. We at CQC have continued to receive the required statutory notification required to be sent to us by law from the managers at the service enabling us to monitor the service.

The manager said that they were aware of what was happening in the houses because each day they completed a clinical walk around the service, spoke to staff and service users as well as observed the environment. Five days a week staff from each department came together to 'Take 10 minutes at 11am. This was to aid communication between departments such as activities taking place, catering updates, staffing issues and environmental issues to be reported. On the session we sat in on communication was clear. Staff spoke of a broken freezer and a person attending a podiatry appointment and the external entertainer coming in along with the hairdresser. This showed us that the manager had systems to make them aware of day to day issues and changes in such a large site.

When the manager had completed their daily clinical walk around they updated their board in the main office from which they took statistical information for a weekly clinical review. This recorded that at the time of inspection 36 people had bed rails in place, there were two people with pressure ulcers, and there were four wounds. We saw that this information was updated as two people were found to have eye infections and another pressure ulcer was noted. This level of information at the management level enabled the manger to have oversight and to track trends and to ensure treatment was effective and followed up upon.

The manager told us that they were in the process of re-auditing all care plans. They had been told this had been completed in December and January, but had not been able to locate any evidence of this completion. The manager told us that they were keen to listen to people using the service and BUPA planned to send out a survey to people in the month of June 2016. An action plan would be developed based upon the outcome. Following the inspection we were information about a recent staff survey. Where issues arose we saw an action plan was in place to address the feedback given from staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a lack of responsiveness to emerging health conditions that ensured peoples needs were met in a timely way.

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 Medicines were not robustly managed. This related to records and storage and audits did not have action plans to drive improvements.

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 There were not sufficient suitably qualified, competent and skilled nurses employed. This was because there was no progress to increase the skill deficit of nurses.