Valewood House Company Limited

Valewood House Nursing Home

Inspection report

Valewood House
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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 24 November 2014. Breaches of legal requirements were found in ten areas. We took enforcement action in two of these areas; staffing and assessing and monitoring the quality of service provision.

Warning notices were issued to be met by 30 January 2015. As a result we undertook a focused inspection on 5 February 2015 to follow up on whether action had been taken to deal with the breaches in these two areas.

You can read a summary of our findings from both inspections below.

Comprehensive Inspection of 24 November 2014

Summary of findings

The inspection took place on 24 November 2014 and was unannounced.

Valewood House Nursing Home provides care and nursing support to adults and older people who have a range of physical and mental health needs, and people living with dementia. The home is registered to accommodate 40 people, with some bedrooms as shared occupancy. At the time of our visit, there were 36 people in residence who ranged in age from 43 to 101 years old. There are two main communal areas, known as the lounge and the cottage lounge. In addition to the main premises, there is a rehabilitation area where people are able develop skills such as cooking. The home has a no-alcohol policy which people are required to sign up to before moving in. The home is in a rural setting accessed by a country lane.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The manager did not have the support of a dedicated deputy manager or administrative support. We observed that the manager was active in supporting people and in liaising with healthcare professionals in relation to their needs. This left little time for clinical oversight and quality assurance. As a result, areas of practice such as medication were not reviewed by the manager. Where issues had been identified these had been discussed with staff but there no evidence of follow-up. Quality assurance processes were not effective in identifying concerns or implementing and sustaining positive changes in the way the service was run.

There were not enough staff employed to ensure the safe running of the service. In addition to the registered manager, the service employed one nurse and had been unable to recruit additional qualified staff. This meant that there was a high use of agency nursing staff. Furthermore, we found examples of shifts where the number of staff on duty was lower than the intended number.

The lack of staff had an impact on all areas of the service. We observed that staff were rushed and had little time to spend with people outside of delivering care to them. People told us that they felt lonely and that they were not able to get attention from staff when they needed assistance. One person said, "I don't feel happy here, the staff don't have time". We found that parts of the home were dirty. There were not enough cleaning staff to ensure that people's bedrooms were attended to on a regular basis. Medicines were not handled safely and records of the medicines administered contained gaps.

Staff had a caring attitude but pressures on their time meant that much of the support they delivered was task-based. They did not pick up on situations that compromised people's dignity or notice when people were anxious and required reassurance. One relative had commented in a survey, 'The staff are very helpful but they do seem to be busy a lot of the time'.

Some people felt unsafe because of the behaviour of others who lived at the home. Staff were not always available to intervene and keep people safe. The manager had not reported safeguarding incidents and there was no information for staff to describe the action they should take if they were worried someone had been abused or was at risk of harm.

The manager knew people well and was able to discuss their support needs in detail. It was clear that they cared about the people in residence. People had access to healthcare professionals, such as the GP, dentist and optician. We found examples of good care and a quick responses to changes in people's needs. We found, however, that this was not consistent. People could not be assured that their care needs would be met.

There was a core team of staff who knew people well and understood their needs and wishes. One relative said, 'I have always found the staff to be lovely, caring people'. We found, however, that records relating to people's care lacked detail. Where risks had been identified, assessments were not always complete and support was not reviewed after incidents to ensure that it still met with people's needs and protected them from harm. Records relating to the monitoring of people's needs, such as repositioning, weight and fluid records had not been used effectively. There was a risk that people's needs would not be met and that changes in their health may not be quickly identified.

Summary of findings

There was no system to check the competency of staff or the effectiveness of the training that staff received. **We recommend** that the manager reviews the induction and training processes to ensure that staff are equipped with the skills to deliver care to an appropriate standard, and prepared for the launch of the Care Certificate in 2015.

People were involved in day to day decisions relating to their care, such as on what they wished to eat and where they preferred to spend their time but did not feel involved in planning their support. Where people lacked the capacity to consent to decisions relating to their care or treatment, the manager was unable to demonstrate that best interest decision making procedures had been followed.

People did not always feel listened to. There were examples of personalised care but this was not consistent. People enjoyed the activities on offer but told us that they had a lot of time with nothing to do. **We recommend** that that manager considers a structured approach to gathering people's views to ensure that they have regular opportunities to share concerns or ideas.

People and their relatives told us that they knew how to complain. Where complaints had been received, these had been thoroughly investigated and responded to. **We recommend** that the complaints procedure is made more readily available to people and visitors. The manager had recently requested feedback from relatives and professionals regarding the service. The feedback was mostly positive. One relative commented, 'I have been impressed by their ability to cope with my mother and meet her needs when so many other facilities have failed'. A mental health professional wrote, 'Valewood has been instrumental in improving this client's holistic well-being and quality of life'.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of the report.

Focused Inspection of 5 February 2015

We undertook a focused inspection to check that the provider had taken action to meet the legal requirements in relation to staffing and quality assurance and the warning notices that we had issued. We found that the warning notices had been met and that the provider was meeting legal requirements. We also observed improvements in the cleanliness of the home and found that the breach in relation to infection control had been met.

Since our last inspection staffing levels in the home had increased. There were additional nursing, care, activities and cleaning staff working each day. This had led to improvements in people's care, a happier and calmer atmosphere in the home and increased time for the registered manager to dedicate to management tasks. People and staff spoke of improvements. The deputy manager explained, "The care plans are more effective. The residents get more attention and they have more to do; we have a dedicated activity coordinator now". A relative told us, "We visit different times, morning, noon and night and always unannounced and never have concerns about staffing levels. [Our relative] always looks clean and looks calm and happy. His room is always immaculate and warm. His finger nails are cut. Staffing is not an issue. He gets help when needed. Staff all appear kind. We have no concerns".

The registered manager had reviewed staffing allocations and, together with the staff team, had produced detailed roles and responsibilities. Staff were clear on what was expected of them and there was a clear system in place to check that all necessary tasks had been completed. There were daily, weekly and monthly checks to monitor and assess the quality of the service delivered. Where improvements were identified, action plans were put in place to ensure that changes were made. The registered manager said, "Now I'm not going to do jobs myself, I'm dedicating my time to checking and giving advice".

There was a noticeable improvement in the cleanliness of the home and especially of people's bedrooms. The laundry room had been refurbished to make it easier to clean and to promote good infection control.

The improvements in staffing and quality assurance had delivered benefits in other aspects of the service. For example medicines audits indicated improvements in the way that 'as required' medicines were recorded. The provider has submitted an action plan detailing how and by when they will meet the regulations in relation to the management of medicines and other areas where we identified breaches. We will return again to check that they have followed their plan and to confirm that they meet the legal requirements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Comprehensive Inspection of 24 November 2014

The service was not safe.

There were not enough staff to keep people safe and meet their needs. There were not enough cleaning staff to ensure that people lived in a clean environment.

People told us that they did not feel safe. The manager had not taken appropriate action following allegations of abuse and staff did not have guidance to refer to.

Risk assessments were in place but had not always been completed in full or regularly reviewed to ensure people were protected from harm.

Medicines were not managed safely.

Focused Inspection of 5 February 2015

We found that action had been taken to improve safety.

Dependency assessments had been carried out and the number of staff, including nurses, on shift had increased. This meant that people received timely support to meet their needs and keep them safe.

Additional cleaning staff had been employed and the laundry room had been refurbished. People now lived in a clean and hygienic environment.

We could not improve the rating for 'safe' from 'inadequate' because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection, which will take place by 24 May 2015.

Is the service effective?

Inadequate

The service was not effective.

People's care plans lacked detail which put them at risk of receiving inconsistent or unsafe care. Records of the care delivered were not always complete which meant that changes in their health may not be quickly identified.

Staff and the manager had not followed the requirements and principles of the Mental Capacity Act 2005. Where people lacked capacity to consent to certain decisions, the manager had not followed best interest decision making procedures.

New staff received limited induction training and staff competency following training was not assessed.

People had access to health care professionals.

Summary of findings

Is the service caring?

Requires Improvement 

The service was not consistently caring.

People told us that they felt lonely and that staff did not have time to be with them.

People were not always involved in decisions relating to their care.

People were not always treated with dignity and respect.

Is the service responsive?

Requires Improvement 

The service was not always responsive.

People felt they were not listened to.

People were not always given personalised care that met their needs and preferences. People hoped for more social interaction and opportunities for individualised activities.

People, their representatives and staff felt able to approach the manager. Complaints had been fully investigated.

Is the service well-led?

Inadequate 

Comprehensive Inspection of 24 November 2014

The service was not well-led.

There was no clear vision for the service or plan as to how they would meet the needs of people with a wide age range and diverse support needs.

The manager did not ensure that identified changes to improve the service were followed through.

Audits and quality assurance processes were not effective in identifying concerns or implementing and sustaining positive improvements.

Focused Inspection of 5 February 2015

We found that action had been taken to improve the management of the home.

The registered manager and deputy managers worked on a supernumerary basis which meant they were able to dedicate time to managing and monitoring the quality of the service delivered.

New systems for auditing the service and monitoring improvements were in place and had delivered positive changes.

We could not improve the rating for 'well led' from 'inadequate' because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection, which will take place by 24 May 2015.

Valewood House Nursing Home

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Valewood House Nursing Home.

We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first, a comprehensive inspection of all aspects of the service, was undertaken on 24 November 2014. This inspection identified breaches of regulations. The second was made on 5 February 2015, and focused on following up on action taken in relation to the warning notices issued against breaches in the legal requirements for staffing and assessing and monitoring the quality of service provision. You can find full information about our findings in the detailed findings sections of this report.

Comprehensive inspection

We undertook an unannounced inspection of Valewood House Nursing Home on 24 November 2014. Three inspectors, a nursing specialist advisor and an expert by experience in behaviour that challenges undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We reviewed three previous inspection reports and notifications received from the manager prior to the inspection. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information from the local authority commissioning team who had recently visited the service. This enabled us to ensure we were addressing potential areas of concern.

We observed care and spoke with people, their relatives and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at ten care records, four staff files, medication administration records (MAR), weight charts, monitoring records for food, fluid and wound care, quality feedback surveys, accident and incident records, minutes of meetings and staff rotas.

During our inspection, we spoke with 11 people using the service, one relative, the registered manager, one nurse, six care staff, the chef, the maintenance manager and one cleaner. After the inspection, we contacted a Community Psychiatric Nurse (CPN) and a Placement Reviewer who had involvement with the service to ask for their views.

We last inspected Valewood House Nursing Home in July 2013 where no concerns were identified.

Focused inspection to follow up

We undertook an unannounced Focused inspection of Valewood House Nursing Home on 5 February 2015. This inspection was done to check that the warning notices issued after our inspection on 24 November 2014 had been met. The team inspected the service against two of the five questions we ask about services: is the service safe; is the service well-led. This is because the service was not meeting some relevant legal requirements which we considered had a major impact on people.

Detailed findings

The inspection was undertaken by two inspectors. During our inspection we spoke with 11 people using the service, two relatives, the directors, the registered manager, one deputy manager, one nurse, two care staff, a member of the maintenance team, one cleaner and one visiting healthcare professional. We observed care and used SOFI. We looked at staff rotas for eight weeks, staff allocations, the new dependency tool, minutes of staff and resident meetings, audits and monitoring records.

Inadequate

Is the service safe?

Our findings

Findings from the comprehensive inspection of 24 November 2014

Some people told us they did not feel safe. One said, "This one here (pointing to another person) is very troublesome, he hits me". Another told us, "I don't feel very secure". We observed a disagreement between residents in the main lounge. Staff did not intervene until the situation had escalated into a loud row. In the incident records we identified cases that should have been raised under safeguarding, such as unexplained bruises and incidents of verbal abuse between people living at the service. The manager confirmed that they had not raised any safeguarding alerts. Action to recognise, report and prevent abuse had not been taken to ensure people were protected.

Staff knowledge of safeguarding varied considerably. Some were able to describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. Others did not demonstrate that they had sufficient knowledge to safeguard the people in their care. The home's safeguarding policy was dated 2010 and had not been tailored to the service. There was no information on display for staff to refer to that described the action they should take, or which external agencies they could contact if they needed to report safeguarding concerns. We found that the manager had not made suitable arrangements to ensure that people were safeguarded against the risk of abuse and had not responded appropriately to allegations of abuse. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks to people's safety had not been adequately assessed. Where risks had been identified, the support plans lacked detail on how the minimise them. This presented a risk that staff would provide inconsistent or unsafe care to people. We found that the support plans for people who required the assistance of a hoist to transfer, lacked detail of the equipment and support required. Assessment tools, such as the Waterlow scale used to identify whether a person is at risk of pressure areas, had not always been completed in full. This meant that staff would be unable to define if a person was at risk and ensure that appropriate support was planned. Following incidents, such as falls or behaviour that could be described as challenging, risk assessments had not been reviewed to ensure that the support provided was sufficient to meet the person's needs and protect them from harm. We found that care had not been planned in such a way as to ensure the welfare and safety of people. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not enough staff on duty to keep people safe and meet their needs. One person told us, "I have to wait a long time" and said, "I can't always get hold of staff". Another told us, "We often have to wait for food for a long time". A third said, "If I need help at night I can't get it. I'm very lonely at night". We observed that staff were busily engaged in tasks but that they were not always available when people needed support. We saw people waiting for assistance to eat their meals, trying to gain staff attention to ask for a drink and incidents between residents that escalated because there was a delay in staff intervening. Staff told us that they had very little time to spend with people and that they had fallen behind in record keeping. One said, "We don't get much time, we're always rushing around". Another told us, "It's stressful, it's absolutely draining".

We asked the manager how the staffing numbers had been determined. They told us, "We work it out by number of clients and number of staff required and then allocate staff to each client". Whilst we saw dependency assessments for some people, these had not been used to determine the staffing hours or skills mix required. People's diverse support needs may not have been adequately considered and there might be insufficient staff on duty to meet their needs. There was one nurse on duty for the 36 people living at Valewood House Nursing Home. The nurse was supported by a senior care assistant and five care staff. Additional support was available from the registered manager, also a nurse, on weekdays. In addition two people received 1:1 support. We looked at the staff rotas for the month prior to our visit. We found that the number of staff on duty had not always met the planned levels. For example there were 11 dates when 1:1 support had not been provided to one of the people who needed it. This meant that people did not always receive support in line with their assessed needs and risks.

The manager relied on agency staff to maintain the staffing numbers. In addition to the registered manager, there was one nurse employed by the service. This meant that shifts

when they were off duty were covered by agency. The manager told us that they had failed to recruit nurses to the service despite significant efforts. She said there was very little access to additional resources to support emergencies or unplanned absence. The manager explained that instances of lower staff numbers were when they had been unable to cover shifts with agency staff. We found that there were insufficient numbers of suitably qualified, skilled and experienced staff to safeguard people's health, safety and welfare. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not enough cleaning staff to ensure that people lived in a clean environment. There was a strong odour of urine noticeable on entering the service and in some bedrooms. In one bedroom we found a soiled continence pad down the side of the bed and underwear behind the bedside table. The room was not clean. There was visible dust and there were flies in the room. We spoke with the cleaning staff about their routines. They told us that there was one cleaner for six hours each day. Once they had attended to the communal areas, they told us that they were only able to clean two of the 35 bedrooms daily. Cleaning records indicated that the room mentioned above had been cleaned twice in June and twice in July 2014. The cleaner told us that they did not always find time to complete the records. We observed that stairways were dusty and that litter had dropped down in the gaps. The cleaner told us that they cleaned those areas on, "odd occasions". The laundry area was dusty. There were cracks in the plaster on the walls and there were gaps between the flooring and the wall. This meant they were not waterproof, easily cleanable and did not promote good infection control measures. We found that there were inadequate standards of cleanliness and hygiene in the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were not managed safely. We observed the nurse pre-preparing lunchtime medications for six people by placing them in pots. The pots did not include any form of identification which put people at risk of receiving the wrong medicines. After administering the medicines in another part of the home, the nurse returned to sign the Medication Administration Record (MAR). This was not good practice as failure to complete the MAR at the time of administration could result in recording errors if the nurse had to rely on memory. In one person's bedroom we found a tablet on the window sill. MAR charts contained gaps which meant that people may not have received their medications as prescribed. Where medicines were prescribed on a variable dose, such as for pain relief, there was no record as to how many tablets had been administered. Records for topical administration, such as for steroid creams, were incomplete and blank in some cases. Refrigerator and room temperature records were incomplete, with omissions for seven days in October and six in November 2014. The service could not be sure that medicines were stored at the appropriate temperatures to ensure their effectiveness and safety. We found that competency assessments for staff administering medicines had not been reviewed annually as suggested in best practice guidelines and that the medication policy had not been reviewed since 2010. This meant that changes to relevant legislation may not have been reflected and acted upon. The monthly audit of medicines was a stock check and did not include checks on administration records, storage or the procedures followed. The above demonstrated that people were not protected against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Findings from the focused inspection of 5 February 2015

Since our last inspection, on 24 November 2014, the staffing levels had increased. From 14 December 2014, the nursing staff on duty during the day was increased from one to two nurses. In addition, a deputy manager was included on each day shift on a supernumerary basis and the number of dedicated activities hours provided had more than doubled. There were no changes made to the night staffing levels.

The staff rotas confirmed the increase in staff on duty. The provider had also increased the number of agencies that they contracted with. Shifts, including for one to one support, had been consistently covered. At the time of this inspection there were vacancies for nurse and care staff. We could see that the provider and registered manager were taking action to recruit to these positions.

We observed positive changes as a result of the increase in staffing. Staff were available and were quick to respond to people's needs and requests. We observed staff intervene

Inadequate

Is the service safe?

quickly to support a person who was becoming anxious and shouting at another person in the dining room. People who requested drinks were supported and staff stopped to reassure or chat with people as they went about their duties. One person told us, "You only have to ask and they will help you". Where people were unable to communicate verbally we saw that staff took time to gain eye contact and explain what they were planning to do. The provider had used a dependency tool to calculate the nursing and care staff hours required to meet people's needs. The staffing level in place exceeded the level recommended by this tool.

Staff spoke positively about the changes. Speaking about the increase in nursing staff, the deputy manager said, "It's definitely freed up my time a lot more. I don't feel so pressured in the clinical side which I'm not trained in". A nurse explained, "Now there are two of us on duty it's made a big difference. We are now giving medication on time. We now audit stock and then record. We have three medicines trollies, two downstairs and one upstairs. Things are definitely better with two nurses. We can do our job properly". A carer told us, "You can see the difference. They (the residents) are occupied. They look forward to the day. [A resident] doesn't lose her temper because she is occupied. We have time, like when they stop me to ask for a cup of coffee. I have time to do it now. You can respond immediately".

We found that there were enough staff on duty to keep people safe and meet their needs. The warning notice in respect of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 had been met.

The provider had also increased the number of cleaning hours at the home. There was a visible improvement in the cleanliness of people's bedrooms and the communal areas. Each bedroom was now cleaned on a daily basis, and spring cleaned monthly. The registered manager told us, "It has been noticed by staff and regular visitors". We found that people lived in a clean environment.

The laundry are had been refurbished and appeared clean. New non-slip flooring had been fitted, the walls had been sealed and repainted and the area behind the washing machines had been boxed in to avoid the build-up of lint and dust. A member of staff told us that staff entered the laundry room via one door with soiled laundry and left via a separate door with clean. They also said, "It's easier to maintain now, it's made it easier to clean".

We found that there were good standards of cleanliness and hygiene in the service. The breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 had been met.

We also noted improvements in other areas, including safeguarding, managing risks to people and the management of medicines. The registered manager had raised safeguarding alerts with the local authority and staff had received further training in safeguarding adults at risk. The increased staffing levels meant that staff were able to monitor people more effectively and intervene quickly to keep people safe. Care plans were being updated and risk assessments, such as the Waterlow scale used to identify whether a person is at risk of pressure areas, were being reviewed, starting with those deemed to be at greatest risk. Competency assessments in medicines administration had been completed for nurses and an additional medication trolley was now in use, making it easier for nurses because medicines and records were located close to the people who needed them. The provider has submitted an action plan detailing how and by when they will meet the regulations in these and other areas where we identified breaches. We will return again to check that they have followed their plan and to confirm that they meet the legal requirements.

Inadequate

Is the service effective?

Our findings

People's needs had been assessed but their care had not been planned in such a way as to meet their individual needs. Care plans lacked detail on how staff should meet people's assessed needs. In one person's care plan for mobility we read, 'Occasionally walks assisted, depends on his mobility'. There was no detail to describe when or how staff should support the person. In a second, staff were advised to, 'Support (person) with boundaries' but provided no information as to the person's particular support needs or what the boundaries were. Whilst many of the staff working at the service knew people well, the service relied on agency staff. The lack of clear guidance meant that people were at risk of receiving inconsistent care or not having their needs met.

People's needs were not monitored effectively. We visited the rooms of two people who used pressure relieving mattresses and required regular repositioning to reduce the risk of pressure sores. There were no repositioning records available. We asked how staff could be sure that the mattresses were set appropriately. We found that there was no guidance and that staff were not asked to check that the equipment was set correctly.

Where people presented with behaviour that could be described as challenging we found that there was little analysis of incidents in order to understand the causes or to introduce a positive behaviour support plan. Incident records lacked detail of serious events and simply recorded, 'Triggers unknown'. The lack of detailed information meant that it would be difficult to establish causation and develop an appropriate behaviour care plan to reduce such occurrences. The above demonstrated that people's care was not planned or delivered in such a way as to meet their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Following our visit, the manager sent us copies of new records introduced to ensure that staff had the necessary information to check that pressure relieving mattresses were set correctly and that there was a record of when people were assisted to change their position.

People were satisfied with the food and drink available. They told us that the food was good and that they were offered choices. We observed that a variety of hot and cold meals were served at lunchtime.

People were not always protected from the risks of inadequate nutrition or hydration because monitoring of this was inconsistent. The food and fluid charts indicated that staff were not monitoring people's food and fluid intake to ensure that they received enough to meet their needs . As fluid records had not been totalled, it was difficult to establish who had sufficient fluid intake and who needed more encouragement and prompting. Whilst we found good examples of weight monitoring, fortified meals and referrals to professionals such as the Speech and Language Therapist (SALT) or Dietician, some records indicated concerns that had not been addressed. We saw that one person had reportedly lost 9.9 kilograms in a month and a second had lost five kilograms over five months. There was no evidence that staff had noticed these changes or taken action. We found that the manager had not ensured that people were protected from the risks of inadequate nutrition and dehydration. Staff were busy serving meals and did not respond to people's requests for assistance. We observed two people who waited over 15 minutes for assistance after being served their meal. People may not have been provided with enough support to eat and drink sufficient amounts to meet their needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Where people lacked the capacity to consent, staff were not following the Mental Capacity Act 2005 (MCA) principles and guidance. The capacity assessments on file did not relate to specific decisions. There were no records of best interest meetings for people living at the service. Best interest meetings should be convened where a person lacks capacity to make a particular decision; relevant professionals and relatives are invited and a best interest decision is made on a person's behalf. Whilst staff were able to share examples of when healthcare professionals such as the GP and relatives were involved in decisions, these were not formally recorded. Other decisions, such as one decision to administer medication covertly and another to authorise the use of a wheelchair strap, had been signed by a relative only. Consent to care and treatment was not sought in line with legislation and guidance. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Following our visit the manager provided

documentation to show that the GP had reviewed the covert administration of medicine and determined that it was in the best interest of the person, who lacked capacity to make the decision.

The manager was aware of a revised test for deprivation of liberty following a ruling by the Supreme Court in March 2014 and had taken action in respect of this. A deprivation of liberty occurs when 'the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements'. We saw that 13 applications had been submitted. Speaking of one person who had capacity to make their own decision with reference to their accommodation at the service the manager said, “If he wants to go, all I can do is open the door”. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

Staff attended two supervision sessions and an appraisal each year. Staff told us that they felt supported and that they were satisfied with the training that they received. Training records confirmed that staff received two days training each year provided by an external company. This covered moving and handling, infection control, health and safety, COSHH, first aid, safeguarding, The Mental Health Act, challenging behaviour and fire safety training. Some staff had attended additional training including in nutrition, dementia and end of life care. Others were working towards diplomas in health and social care. We asked the manager how they assessed the effectiveness of training since a significant amount of information was covered in a short time. They told us that there was no process to formally assess their knowledge and competency. This included new staff who completed their induction in three days. **We recommend** that the manager reviews the induction and training processes to ensure that staff are equipped with the skills to deliver care to an appropriate standard and prepared for the launch of the Care Certificate in 2015.

People had regular access to health services including their GP, Community Psychiatric Nurse (CPN), opticians and dentists. Records of these appointments were kept in the person’s care plan. We noted that changes, such as new medication or a move to pureed food, had been included in the handover records. Where people had specific health needs, such as diabetes, we saw that records of their blood sugar were up to date. They were supported to attend regular appointments with healthcare professionals such as the chiropodist.

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were kind but that they often felt lonely. There was a core staff team who knew people well and understood how they liked to be supported. We found, however, that most of staff interactions with people were task-based such as offering a drink, supporting people to move or assisting them to the toilet. We observed that one person who was anxious did not receive support from staff until we brought it to their attention. Some staff supporting people to eat engaged with them but others assisted people in silence. One member of staff approached a person with a cup and, without introduction or explanation, started to give her a drink. Another placed a clothing protector around a person without seeking consent or giving an explanation. There were examples of warmth and staff providing encouragement and reassurance, but the majority of interactions were functional, rushed and did not treat people with dignity.

Over the lunchtime period we observed the care and support provided to people in the two lounges and conservatory area. Because staff were busy with other tasks, they did not notice incidents that compromised people's dignity. We observed one person with a cold whose nose was running into their food. Another person sitting with others at a table was served 20 minutes after them. Confused by this delay, the person attempted to slice up their paper serviette. When the meal, came the person ate it with their knife. Before people had finished their lunch, staff were clearing tables and hoovering around them.

We observed that a board designed to help orientate people had not been updated to show the correct day and date. Several clocks were not showing the correct time.

One person told us that the clock in their room had stopped, "A good while ago". We observed that some people wore worn, stained or ill-fitting clothes. One relative said, "I don't know whose jacket that is that he is wearing today, it's certainly not his". Another person said that they would like to have a matching pillow case and duvet cover and commented that the bed linen wasn't changed very often. The examples above demonstrated that staff did not always promote people's dignity and that people were not always treated with consideration and respect. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When a person moved to the service they were shown around. A checklist was completed to ensure that relevant details were shared with them. People that we spoke with did not recall being involved in discussions relating to their care and support. One person said that they were informed after the event. We observed, however, that staff supported people to make decisions and every day choices. We heard a member of staff ask, "I've got your meal, where would you like it?". People sitting in the lounge were asked which programme they wished to watch on the television. People were able to choose where they spent their time and were able to go outside to use the gardens or have a cigarette.

We observed that staff supported people to be independent. One person was assisted to cook a meal in the rehabilitation kitchen at the service. Another was given time and encouragement to stand independently from their armchair. Two people had mobile telephones and others were supported to use the home's portable handset to keep in touch with friends and relations. One relative had commented in a survey, 'I very much appreciate being able to speak to her every week on the phone'.

Requires Improvement

Is the service responsive?

Our findings

During the morning of our visit we observed that most people were sitting in the lounges with little or no stimulation. One person told us, "I get bored". Another said, "Some people just sleep but I can't sleep all the time". The service did not employ activity staff. There was a programme of visiting entertainers which included music, theatre and outings one to three times each month. We also observed flower arranging and Christmas craft activities facilitated by one of the Directors who provided activities in the home on two days each week.

Some people were supported on a 1:1 basis with activities that they enjoyed or to access the local community. In the records for one person we read, 'Went out with (member of staff) to buy a magazine and material for her art work'. Another person's request to visit London had been facilitated. We found, however, that much of the time people hoped for more social contact. One person said, "There are a few activities to go along to but not enough. A lot of the time we just sit here with nothing to do". A member of staff told us, "I would like to spend more time with the clients".

People did not feel listened to. One person said, "I suppose they look after me. I don't moan, what's the point?". They also explained that their mattress made a loud buzzing noise which disturbed their sleep and that although this had been mentioned to staff, nothing had been done about it. Another person was no longer able to attend worship in a local church. The reason for this was outside of the manager's control but the person had not been supported with suitable alternatives. They told us that their religion was important to them and that they would like more than irregular visits from a local priest. The above examples demonstrated that people were not always supported to make, or participate in making, decisions relating to their care or treatment. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not routinely asked for their views. Four people had completed surveys on the menu, bedrooms and activities in October 2014. Some requests, such as for a new bookshelf, had been actioned immediately. There were also periodic surveys to gather people's views on events like the Christmas carol concert and on the items they would like stocked in the residents' shop. The manager told us that residents' meeting were not always the most effective way of gathering people's views and that 1:1 discussions worked better. Records of the 1:1 discussions were not available to view. **We recommend** that that manager considers a structured approach to gathering people's views to ensure that they have regular opportunities to share concerns or ideas.

Relatives and visiting professionals had been invited to provide feedback in October 2014. Responses had been received from nine relatives and four professionals. They were then invited to a meeting where views were discussed. People and relatives felt able to complain. One relative said, 'I feel quite able to talk to any of them if I have a query'. Where complaints had been received, these had been thoroughly investigated and responded to. Complaints forms were available in most bedrooms. We noted that the complaints policy was not displayed within the home or detailed on the complaints forms. People who wish to complain might not know what response to expect, the timescale or the action they could take if they were not satisfied with the outcome of a complaint. **We recommend** that the complaints procedure is made more readily available to people and visitors.

Inadequate

Is the service well-led?

Our findings

Findings from the comprehensive inspection of 24 November 2014

The service promotes itself as a, 'Family owned and run care home, specialising in person-centred care for those with dementia and enduring mental disorder over the age of 40 years, excluding learning disability'. People living at the service had a wide range of different support needs and their ages ranged from 43 to 101 years old. Staff that we spoke with were not able to describe the vision of the service. There was no plan in place to set out how the service would meet such a range of individual care and support needs. One person told us that they did not have a peer group at the service. They also said, "I'm not mentally unstable in the same way as most of these". People did not feel safe at the service and said that much of the time they were bored or lonely.

The staffing numbers meant that staff were not always able to provide person-centred care. The manager explained that they had previously had two deputy managers and that the day shift was staffed by two nurses. We were told that they had not been able to recruit nurses or a dedicated deputy manager to work at the service. In this period the manager told us that people's support needs had increased. She explained that sufficient nursing oversight would ensure appropriate wound care, input into challenging behaviour and techniques, a detailed review of accidents and incidents and consistent guidance for care staff. The service had continued to operate and accept new admissions, in spite of the staffing deficit. As a result we found that people's needs were not being met and that the service was not operating safely.

Staff told us that they felt supported by the manager. One said, "I have someone to talk to, to ask for help and advice". Despite considerable efforts, the manager was unable to run the service effectively. As a nurse, the manager was involved in day to day healthcare needs and in liaising with healthcare professionals such as the GP. The manager had a very good understanding of people's needs but was left with little time to dedicate to management tasks. We found that areas of responsibility had been delegated but that there was little management oversight or follow-up. The manager said, "We talk about it at the time and then I leave it with the member of staff". When we asked about medication, the manager said, "I can't stretch to the point where I'll be in charge of meds". We found that actions from a pharmacy audit in May 2014 had not been followed through because the member of staff assigned had since left employment. Where issues had been identified in staff supervision, there was no record of follow-up or monitoring to check progress. During this inspection visit we found several areas of concern and breaches of the regulation which had not been identified and acted upon as part of on-going quality monitoring.

We saw examples of audits designed to monitor the care delivered and to drive improvements. We found, however, that these audits had not been used effectively and that there was little evidence of follow-up or progress. Care plans were signed as reviewed on a monthly basis but were not effective in identifying changed needs. A personal care audit looked at records of personal care delivered and the frequency of bed changes. The audit had picked up the same issues in July, August, October and November 2014. Spot checks on bedrooms had been reduced from weekly to monthly checks as improvements were noted. On the day of our visit, we found bedrooms in need of cleaning which suggested that improvements had not been sustained. We found that the manager did not have an effective system to regularly assess and monitor the quality of the services provided. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records were not up to date. We found that records of the care delivered including fluid, repositioning, medication and incident records contained gaps or lacked detail. Records pertaining to the management of the service such as 1:1 discussions with people to obtain their views and cleaning records were not always available or accurate. This put people at risk of receiving unsafe or inappropriate care and treatment because there was a lack of proper information about them. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us that the owner worked in the service most days and was office-based. The owner did not conduct any formal quality assurance visits and did not provide supervision for the manager. We noted that requests from staff meetings, such as for additional cleaning staff, had not been acted upon. Staff told us that they had not received a response to their suggestion.

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Is the service well-led?

Findings from the focused inspection of 5 February 2015

Since our last inspection, on 24 November 2014, the registered manager and deputy managers had been included in the staffing rota on a supernumerary basis. This meant that there was time available to dedicate to management tasks and monitoring the quality of the service delivered.

The provider and registered manager had taken steps to improve the quality of people's experience living at the home. They had written to relatives and visitors enclosing a copy of our inspection report from the visit in November 2014 in an open and transparent manner, inviting them to share any concerns. There had been regular staff meetings and changes had been agreed collaboratively. The provider told us, "We fell behind on the quality assurance system" and said, "If there are issues, we will deal with the issues. We want a culture of openness". The provider and registered manager met on a daily basis to discuss the service.

There was an improvement in the atmosphere at the home. Staff had time to spend with people and people appeared to be happy and relaxed. We observed staff chatting with people and others working jointly on craft activities in preparation for Valentine's Day. The registered manager said, "It's a nicer atmosphere because the minute you have enough staff everything is changing. We have time to give clients without making them wait". Staff, including agency staff, knew people individually and spoke with them about their particular interests or wishes. As one agency worker told us, "Staffing has improved lately. We have more staff and they are trying to have the same ones. I have been doing lots of shifts here. It's better for the residents to have familiar faces".

The registered manager had agreed clear allocations of work with the staff team. This included detailed roles and responsibilities for each nurse on duty and a schedule of checks for the deputy manager. Tasks allocated to the nurses included, 'morning medication, 'attend any reviews/ meetings if necessary', 'check dressing and wound assessments' and 'ensure intake charts have been completed for food and fluids'. The deputy manager told us, "We do the handover with the nurse and they tell me where they are at with the documentation. I do a spot check each day on two or three areas, such as the intake charts, the air mattress checks, the fridge temperature checks". We noted examples of issues that had been identified by this process in the deputy's feedback to the registered manager. For example we read, 'Spot checks on personal care entries – two missing. Chased relevant staff for info and completed the entries'. This meant that staff were clear on what was expected on them and that any gaps were quickly identified and remedied.

The registered manager carried out a weekly check on care delivery and documentation. This included the review of a number of people's care plans. It was clear that action had been taken as a result of these checks, for example risk assessments had been updated and the detail regarding people's needs or support enhanced. Each check had resulted in an action plan which had been monitored to ensure that the necessary changes were made. The registered manager told us, "I look back to make sure we've got a closure".

We looked at a selection of audits used to monitor the delivery of the service. A new medication audit had been introduced and the manager had completed competency checks on each of the nurses who worked at the service. The audit had resulted in positive changes, for example in December we read, 'PRN (as required) medication still needs in some cases to record the amount of tablets been given'. In the most recent audit, dated 3 February, we read, 'All PRN medication signed for and states how much administered'. The pharmacy had also visited the home at the registered manger's request to complete an audit. A follow-up audit was scheduled at the end of February 2015 and a clear action plan was in place. Other audits included room checks, checks on pressure relieving equipment such as mattresses, a review of the personal care records and an inspection of slings used when hoisting people. In each case any actions were clearly documented indicating who was responsible and a date for completion. There was evidence of progress in the records in statements such as, 'Hole in the wall in [bedroom name] has been repaired' and in our observations. We saw that clocks were working and showing the correct time, records of checks to ensure that pressure relieving equipment was functioning correctly were in place and had been completed correctly.

A monthly review of accidents and incidents had been completed. This helped to identify any patterns and to take preventative steps. We saw that interventions, such as putting in place one to one support had been effective at

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Is the service well-led?

reducing the number of incidents involving one person. For others we saw that referrals had been made to healthcare professionals such as the GP, Dementia Crisis Team or Community Psychiatric Nurse (CPN).

We found that the registered manager had put in place a system to regularly assess and monitor the quality of the services provided and to identify assess and manage risks relating to people's health welfare and safety. The warning notice in respect of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 had been met.

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 did not take formal enforcement action at this stage. 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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People were not safeguarded against the risk of abuse because the manager had not taken reasonable steps to identify the possibility of abuse and prevent it before it occurred, or responded appropriately to any allegation of abuse.**

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Care had not been planned and delivered in such a way as to ensure the welfare and safety of people or to meet their individual needs.**

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 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with the unsafe use and management of medicines.**

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 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided for them, or for establishing and acting in accordance with their best interests.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not protected from the risks of inadequate nutrition and dehydration and did not receive appropriate support to enable them to eat and drink.

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 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People's dignity was not always ensured and people were not always treated with consideration and respect. People were not enabled to make, or participate in making, decisions relating to their care or treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were at risk of receiving unsafe or inappropriate care and treatment because there was a lack of proper information about them and management records were not appropriately maintained.