Ringdane Limited

Gosmore Nursing and Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 27 October 2016 and the 21 November and was unannounced on both days.

The service was registered with the Care Quality Commission to provide regulated activities in June 2016. However, the provider is part of the same corporate brand as the previous provider and the management within the service remained the same when it was transferred to the new provider. When the service was last inspected in August 2015 we gave it a rating of 'Requires Improvement' overall. We found that, although there were enough staff on duty on the day of our inspection in August 2015, this was not always the case. Also, the way in which staff were deployed and the layout of the building meant that people's needs were not always met. During this inspection we found that this continued to be the case. Although the number of staff on duty had been calculated using the dependency levels of the people that used the service, it had not sufficiently compensated for the difficulties caused by the layout of the building. There were no members of staff visible in some corridors for lengthy periods during the inspection. People and their relatives reported that people continued to have to wait for an unacceptably long time before their needs were met. The number of domestic staff employed was insufficient to ensure that the home was clean and free of bad odours at all times. The home was very hot and this accentuated the bad odours in corridors and people's rooms. Floor coverings, furniture and equipment were stained and dirty. Some bed rails were damaged. Wheelchairs and mattresses were embedded with food debris and dust.

When we inspected the service in August 2015 we had also identified that improvements were required in respect of supporting people to eat their meals and the assessments of people's capacity to make and understand decisions in accordance with the Mental Capacity Act 2005. Improvements were also required in respect of care planning for specific medical conditions, activities, using people's feedback to drive improvements to the service and quality assurance. We found that although some improvements had been made in all these areas further improvement was still required in other areas.

The service provides accommodation for people who need nursing or personal care for up to 60 people. At the time of this inspection there were 54 people living at the home. Care was provided to people in two units. One unit was spread over two floors, whilst the second was housed over three floors. There were separate communal areas for both units on the ground floor, although these were adjacent and connected to each other.

There was a registered manager in place. 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. They were supported by a deputy manager and regular visits from the provider's regional manager.

People told us that they felt safe at the home. However, some people did not have call bells that they could use to summons assistance if they needed it and we could not be certain that management plans to reduce

the risk of harm to people were followed. Whilst systems for the ordering and storing of people's medicines were robust, people did not always get their medicines as they had been prescribed. Some people received medicines that were to be given before food after they had eaten their breakfast. Other people who had been prescribed creams to be applied to their skin did not have this done as often as had been recommended.

There was a robust recruitment process in place which enabled the provider to be confident that staff were suitable to work at the home. However, some staff had poor language skills and we were concerned about their ability to communicate effectively with the people who lived at the home.

People did not always receive sufficient drink to protect them from the risk of harm, particularly if they were at risk of urinary tract infections. They also were not always offered the food that they had chosen from the menu. Although food and fluid intake was monitored by staff when there were concerns, the staff were unaware of what use was made of the information to protect people from harm.

Although the requirements of the Mental Capacity Act 2005 (MCA) appeared to be met in the way care was delivered, not all staff had received training in this or were aware that some people living at the home were subject to Deprivation of Liberty Safeguards for their own protection. Staff had mixed opinions about the training that they had received, although the registered manager was able to show us that 95% of staff training was up to date. Staff were also supported by regular supervisions.

People found staff to be caring but their dignity was not always protected. They were not bathed as often as they wished or needed to be. Some people were left partially undressed and uncovered in chairs or beds in their rooms. The doors to the rooms were propped open and visitors or other people who walked along the corridors could see them. People were not taken to the toilet as frequently as they wished and had to 'go' in their pads.

Care plans had been developed but neither people nor their relatives had been involved in the development of these. The care plans were quite personalised and detailed. However, they were not always followed by staff. People's needs were not always responded to and some people were at risk of social isolation.

There was a complaints system in place. However, people and relatives had little confidence that complaints would be resolved to their satisfaction. Where areas for improvement had been discussed with people and their relatives the resulting actions had not always been effective in maintaining an improvement.

Documentation in care records was not always completed correctly.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always receive their medicines as they had been prescribed. There was also inconsistent practice in recording of medicines that had been prescribed on an 'as needed' basis.

Management plans for the minimising of identified risks were not always followed.

There were insufficient staff to provide for people's needs at all times.

The premises were dirty and there were bad odours around the home which were accentuated by the high temperature at which the home was maintained. Equipment was worn and had embedded dirt and debris, as did some of the chairs and mattresses.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always given sufficient drink or the food that they had chosen. Some people were not given a choice of food. People did not always receive the support they needed to eat in an appropriate way.

Documentation was in place in respect of assessments carried out in accordance with the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). However, not all staff were aware of the requirements of MCA or that some people who lived at the home were subject to DoLS.

Records showed that staff were trained although staff had mixed opinions about the effectiveness of their training. The registered manager monitored the practical implementation of the training staff had received.

Is the service caring?

Inadequate

The service was not caring.

People were not assisted to wash or bathe as often as they wished or needed. They often smelled badly and had unwashed hair.

People were not always dressed or covered appropriately to protect their dignity and were left exposed to the view of others.

Staff communicated with people appropriately.

Visitors were welcome at any time.

Is the service responsive?

Inadequate

The service was not responsive.

People had not been involved in the development or review of their care plans and care plans were not always followed by staff.

People did not have their needs met in a timely manner.

Some people were at risk of social isolation either because they were being cared for in their room or because it was difficult to access the communal areas on the ground floor from their room.

When people had made complaints these had not always been responded to in a way that satisfied the complainant.

Is the service well-led?

Inadequate

The service was not well-led.

Information gathered during quality audits was not always accurate, complete or acted upon effectively.

The registered manager had failed to take effective action to ensure that identified improvements to the service requested by people or their relatives were made.

Documentation in respect of care records was not always accurate or up to date.

Gosmore Nursing and Care Centre

Detailed findings

Background to this inspection

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

The first inspection visit took place on 27 October 2016 and was unannounced. The inspection team included two inspectors, an Expert by Experience and a specialist advisor. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They have experience of people living in a care home setting. The specialist advisor is a registered nurse. We carried out a second visit to the service on 21 November 2016 because we had on-going concerns about the standards in the home.

This inspection was brought forward as a result on concerning information that we had received. Therefore we had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with 15 people and five relatives of people who lived at the home. We also spoke with eight care staff, one nurse, the activities person, one member of the domestic staff, the chef, the deputy manager, the registered manager and one of the provider's regional managers. We also spoke with a visiting social care professional.

We reviewed records of accidents and incidents. We looked at the staff roster and staffing dependency assessment tool. We observed how care was delivered and reviewed the care records and risk assessments

of 17 people who used the service. We also looked at 14 people's daily records and checked medicines administration records. We reviewed information on how the quality of the service and complaints were monitored and managed and how people had been able to provide feedback and identify improvements they wished to be made to the service. We examined the recruitment files of four members of staff and looked at the supervision and training records for staff at the home.

Inadequate

Is the service safe?

Our findings

When we inspected the service in August 2015, the provider was another subsidiary of Four Seasons. We found then that, although the number of staff on duty had been calculated based on the dependency of the people who lived at the home, there were insufficient trained and qualified staff to meet people's needs. We found that this was still the case during this inspection. One person said, "It is sometimes half an hour or more before they come to me." A relative told us, "I come every day between 2.00pm and 4.00pm. I sit in the conservatory with [relative]. It's important in the afternoon when there are no staff about. I can go and get help for the residents if they need to use the bathroom." Another relative told us, "You try and get someone [staff to support people] around 2.15pm. They don't like it."

We noted that the home was very large and had groups of rooms in small corridors. Many people were being cared for in bed. We were able to walk around for 15 minutes, going in and out of rooms, without seeing a member of staff. We saw that people were still in their nightclothes and some people who had catheters to drain their urine had not had their night bags removed at 11.15 am. On the second day of our inspection the registered manager told us that, following our first visit and the concerns we raised with them, they had arranged for an additional care worker during the day. However, other than in the communal areas, we still did not see any visible staff presence around the building. People also told us that there was still a delay in their needs being attended to.

Staff did not think that there were enough trained staff to properly care for people. One member of staff told us, "We need someone to sit down and look at the needs of the residents and calculate exactly how many we need to be kind to the residents and to provide good care." Another member of staff said, "When we have had new staff recently many of them have had little English. It can be very challenging. We don't just want and need staff we need the right staff." Another member of staff told us, "The new ones are straight into the job because we are so short but it does not give them time to learn. Many of them have not been carers before. This means although we have a body we are still short staffed because they can't work alone and they need to be shown everything." We noted that some care workers were unable to answer the questions that we asked of them and were unable to conduct a simple conversation. We asked one care worker, who was distributing hot drinks to people, whether they enjoyed their role. They appeared to be unable to understand what they had been asked. They were, however, able to tell us that they had worked at the home for two months as a permanent member of staff. The majority of people who lived at the home spoke only English. We were concerned that the care worker would have been unable to understand them when they tried to make their needs known.

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

The staff we spoke with told us that they had been provided with infection control training and that training was regularly updated. One staff member said, "We recently had updated training on hand washing techniques." Another staff said, "The manager from time to time would do spot checks to make sure the cleaning is okay." Staff were also aware of the need to provide barrier nursing when people were suffering

from infections. However, we found that the arrangements in place for keeping the service clean and hygienic were ineffective. People were not therefore protected from acquired infections. One person told us, "I go downstairs for my lunch and I suppose that is when the cleaner comes in but in truth the carpet never looks and different to now. So I can't tell you when my room is cleaned because in [number] weeks of being here I have never seen them do it." Some of the communal areas of the premises and some bedrooms had an unpleasant aroma. One room smelt very strongly of stale urine and we saw that the crash mats next to the bed were dirty with pools of stains. We saw that floor coverings in some areas, such as corridors, bedrooms and bathrooms were stained and frayed. In bedrooms that we checked we found that bedframes and mattresses were covered in dust and in some instances food debris. Also commodes and armchairs in some bedrooms had an unpleasant odour. We noted bed rails that had worn so badly that the flock lining was coming out and the wooden rails were exposed. Wheelchairs we examined were embedded with food debris and dust, as were some dining room chairs and armchairs in the communal areas. Window sills and skirting boards in bedrooms, corridors and lounge areas were covered in dust and cobwebs.

We checked the cleaning record for the period 1 September 2016 to 27 October 2016; and found that it reflected that bedrooms and areas of the service had been cleaned daily. The domestic supervisor confirmed that bedrooms and communal areas were cleaned daily; but deep cleaning of people's bedrooms, which was supposed to occur on a monthly basis, had not been taking place. Records seen reflected that four bedrooms had been deep cleaned in September and a further three in October when we visited. The domestic supervisor told us that there were insufficient staff to complete all the cleaning activity needed. The registered manager told us that they had requested funding for an additional 22 hours per week for cleaning activity.

On the second day of the inspection the registered manager told us that they had arranged for an additional cleaner to work for three afternoons a week. The deputy manager told us that the additional cleaner was carrying out a deep clean of each room. They had completed about two thirds of the rooms. We saw that a new cleaning schedule had been introduced with effect from 1 November 2016. This identified tasks that were to be completed on a daily, weekly and monthly basis. The deputy manager carried out daily checks and recorded these on the schedule. However, the schedule did not identify which rooms had been deep cleaned on any specific day as all the daily tasks had been signed by the same person on each unit. We noted that none of the weekly or monthly tasks had been signed off as having been completed.

On the second day of our inspection we saw that some areas of the home had been cleaned, although not always effectively, and areas still had a bad aroma. The registered manager had introduced plug in air fresheners but these had little effect. The registered manager told us that they had identified that the smell was embedded in the carpets in corridors and many of the bedrooms. Although they had tried cleaning the carpets the smell had not been removed and they had asked for them to be replaced. There was no time period for all of this to be done, although the replacement of carpets in two of the bedrooms had been scheduled. We also noted that the doors to nearly every room had holes in them where various signage had been removed. One door had several large holes where various locks had been replaced. These prevented the doors from being cleaned effectively and presented an infection risk to people who lived at the home.

We also found that some of the bedding on people's beds, whilst having been washed, was stained. The registered manager told us that they had ordered new sheets and accepted that stained sheets should not be used to make people's bed. We looked at the laundry arrangements. This was over two rooms. In one room the dirty laundry, including that contaminated by body waste which was in red laundry bags, was in large bins waiting to go into the washing machines. The tumble dryers and the industrial iron used for sheets was also in this room. The clean bedding was ironed and placed on top of the tumble dryers before being stored away. There was a risk that the clean bedding could become contaminated as the only exit from the

room required staff to pass the dirty laundry. People's clothing was ironed in the second room, before being taken to their rooms.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received training in the safe handling and administration of medicines; and their competencies were regularly assessed. However, we found that people did not always receive their medicines as they had been prescribed. One person told us that they used to have some of their medicines before they had breakfast but recently they were given their morning medicines at the same time, after breakfast. We looked at this person's care plan which indicated that they had been receiving some of their medicines before breakfast when they had first been admitted to the home. However, when the GP who attended the home took over responsibility for prescribing this, they had not specified that these medicines should be administered before the person had breakfast. This had not been queried with the GP. We asked a nurse to check this medicine in the British National Formulary (BNF), which gives authoritative and practical information on the selection and clinical use of medicines. The BNF stated that this medicine should be given preferably up to 30 minutes before food or caffeine. Another medicine that the person had been prescribed stated that it should be taken with or just after food. The nurse told us that the person had breakfast at about 8.30am. The morning medicines administration round started at about 9.00am. The nurse told us that this person was not the only one who used to have medicines before breakfast but that they did not have enough time to carry out two morning medicines administration rounds so all morning medicines were given after breakfast. On the second day of our inspection the registered manager told us that people's medicines were administered before breakfast by the night staff. However, this did not happen everyday. One person told us, "I get some before breakfast, sometimes. This does not happen every day."

On one person's medicines administration record (MAR) we saw that they had been prescribed for a specific cream to be applied twice daily, in the morning and at night. There were five days when no signature had been recorded to indicate that the cream had been administered. We raised this with the deputy manager who was unable to offer an explanation for the omissions or to confirm that the cream had been applied. We were therefore not certain if the person had received the treatment as prescribed.

We also found that there was some inconsistency with the practice for how medicines that had been prescribed to administer only when needed (PRN) were recorded. We were told if a PRN medicine was offered to an individual, and taken, staff would record their signature to confirm it was given. In some instances we saw that entries had been made to indicate when people had been offered but had refused their PRN medicines whilst in other cases the MAR was left blank..

Although people and their relatives reported concerns about the length of time it took staff to respond to their call bells, not all people who were cared for in their rooms were able to access a bell to call for attention should they need to. One person told us, "I don't have a bell. I don't have anything to press." Another person said, "I don't have a bell. I would like one so I could get someone." In one room we saw that the call bell was attached to the bedding but the person was sitting in a chair out of reach of the bell. The absence of a call bell, or them being out of reach meant that people could not call for assistance in the case of an emergency. The registered manager told us that they had no way of monitoring how long it took for call bells to be responded to. Each unit had a separate system and neither could produce reports for the management to review call times. The managers could only monitor the length of time it took staff to answer calls by timing the audible alerts around the building. There were no records to indicate that such checks had been completed.

On one unit some rooms had traditional corded bells whilst twelve had pendant alarms worn round people's necks. Some people who had pendant alarms were unable to remember that they had them and shouted when they needed assistance. However, due to the scarcity of staff on the unit other than in the communal areas, this was not always successful in obtaining the help they required.

There were personalised risk assessments for each area appropriate to people who lived at the home. Each assessment identified the people at risk, the steps in place to minimise the risk and the action staff should take should an incident occur. We saw that risk assessments had included risks associated with people's mobility, risk of falls, the use of bedrails and the risks posed by people having their own furniture in their room, which they did not wish to be bolted to the wall. We saw that where one person had been assessed as at risk of choking staff were advised to ensure that their food was cut up to reduce the risk of harm to them. Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. Actions to reduce the risks posed to people were amended when this was appropriate. Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These included looking at the care plans and talking about people at shift handovers. Where people had been assessed as at risk of developing pressure ulcers management plans had been implemented. People who were immobile were assisted to turn at regular intervals to relieve pressure on their skin. These turns were recorded including the position that the person had been turned to. We saw that one person for whom the management plan had been implemented had been recorded as on their back at each turn, although they were on their side when we observed them. This showed that the charts kept were inaccurate and people may not have been protected from the risk of harm as we could not be certain that the management plan had been followed or to what positions people had been moved.

The failure to administer medicines as they had been prescribed, the inability of people to be able to summon assistance when they needed it and the failure of staff to follow management plans for risks were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment documentation for four members of staff who had recently started work at the home. The provider had robust recruitment and selection processes and gaps in an applicant's employment history had been explored during the interview process. We saw that appropriate checks had been carried out which included Disclosure and Barring Service Checks (DBS), written references, and evidence of their identity. This enabled the provider to confirm that staff were suitable to support people who used the service.

People told us that they felt safe at the home. One person said, "[I feel] safe here, yes I do. They are all nice people here. The other service users I get on well with them all." Another person said, "I think I feel safe here. They do pop in from time to time to see me." The home was secure and visitors were required to sign in and out of the building. This protected people who lived at the home from harm because staff knew who had come into the home. The information would also be used to ensure that everyone in the building was accounted for in the event of an emergency evacuation. However, one of the inspection team, who was not wearing identification and was walking all around the home, was not challenged by any member of staff as to who they were or why they were in the building.

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Staff told us they had been provided with safeguarding and whistle blowing training. Some were able to explain how they would recognise and report abuse. One staff member said, "If I witness abuse I would report it to the manager." A second staff member commented, "I know about the different types of abuse and would definitely report anyone I thought was behaving in a way they shouldn't be."

Senior staff had carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the handling of potential hazardous substances. Checks were also carried out to ensure that equipment had been serviced and portable appliances had been tested. Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained within it remained current. Copies of these were in people's care records and in the emergency folder, which included the business continuity plan and emergency contact numbers. This enabled the staff to keep people safe in the event of an emergency.

Accidents and incidents were recorded on an electronic system. Each entry triggered an email to the registered manager which detailed the actions required to follow up on the incident. Entries were rated within the system on a scale of one to five. In cases rated highly the system triggered emails to senior managers within the provider's organisation. This enabled the registered manager to monitor accidents and incidents for any trends and to identify actions that may reduce the risk of a similar incident recurring.

Requires Improvement

Is the service effective?

Our findings

During the inspection in August 2015 we found that people were not always assisted to eat their meals. During this inspection we observed the lunch time meal experience. We asked whether people were assisted to clean their hands before and after they had eaten. the deputy manager told us that wet wipes were used. however, when we spoke to staff who were assisting people at lunch time they told us that they had not offered people a wipe to clean their hands before they ate. This put people at risk of developing an infection due to poor hand hygiene.

Staff were available to assist people to eat their meals but the way in which this was done was inconsistent. We saw one member of staff assisting someone throughout the meal. They were attentive and focused on the person they were helping. However, we also saw another member of staff moving in and out of the dining room. The person they were assisting had to wait for extended periods of time for them to return to assist them with eating their dessert. This did not give a satisfactory experience for the person who was being assisted to eat their meal.

People had mixed opinions on the food and drink that they received. One person told us, "It is very nice sometimes but sometimes it isn't. I am not sure why. I don't get a choice in here in my room, they just bring it to me." Another person said, "I think the food is excellent. Just too much of it for me you see. We seem to be eating all day, I am not used to that. The menu is not followed at all so it makes it difficult to choose what you would like to eat. What we chose is not what we get." We noted that people were given blackberry and apple pie as a dessert. However, the menu published on the wall in the dining room stated the dessert was rice pudding, yoghurt or ice cream. One person said, as their dessert was put down, "This was supposed to be rice pudding. That's what I chose yesterday." Staff did not respond to them. One person told us, "Nine times out of 10 you don't get what's on the board. Everyone jokes about it but even so, the food is very good."

On the second day of our inspection we noted that people had been given rhubarb and custard instead of the carrot cake and custard shown on the menu board in the dining room. When we asked the chef why people had not been offered the food they had previously chosen they told us that, "Sometimes the deliveries do not arrive in time."

Several people who were being cared for in their rooms did not have drink available to them. One person did not have a jug of water or a beaker in their room. Their relative went to get one when we asked about it. Another person had a beaker of water on their table that was designed to be over their bed but it was across the room against the wall and out of reach. A review of fluid charts within people's care records showed that the first drink people were offered was at 9am and last drink offered was at 9pm. This meant that people went 12 hours without being offered a drink. This put people at risk of harm, particularly those people who were at high risk of dehydration or urinary tract infections because they had catheters.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the chef who told us that the menu was prepared on a four weekly basis and took into account people's likes and preferences. They told us that they attended a residents meeting at which people had been asked what they would like to see on the menu. The chef had introduced different meals to the menu that reflected people's likes and dislikes. They told us that they catered for people's specific dietary needs. We saw a whiteboard on the wall which gave information on specific needs, such as whether a person was suffering from diabetes or whether they needed soft or pureed foods. The chef told us that where people had diabetes they made sugar free versions of the food choices other people had. For example, on the day of our inspection people who had diabetes had been offered a sugar free version of the fruit pie.

Staff told us that people's weight was monitored on a monthly basis but more frequently if there were concerns. One member of staff told us, "We weigh them every month, if they are losing weight we may weigh them weekly and check on what they are eating. If they are not eating properly help them to eat their food. We have drinks charts and food charts. I don't know who looks at these." Another member of staff told us, "We monitor them daily, weigh them monthly. If they are losing weight we would consult the GP to ask for guidance. We would weigh them weekly."

During our last inspection in August 2015 we found that the documentation was not always clear as to what aspects of care were covered by the capacity assessments that had been made. During this inspection we found that, although the documentation had improved, not all staff had received training on the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the DoLS.

Two members of staff we spoke with told us that they had not been trained in MCA and that as far as they were aware no person living within the home was subject to DoLS. However, three of the care records we looked at showed that DoLS was in place for the individual concerned. The care records showed that capacity assessments had been completed appropriately and people were able to make their own decisions whenever possible. The records for one person, who was able to make and understand decisions, showed that they understood why the front door to the home was locked. They had declined to be given the number so that they could exit the home if they wanted to. In another record it showed that where a person had lacked capacity to make their own decisions the best interest's decision meeting had been attended by the GP, the person's next of kin and home staff. We saw that there had been capacity assessments in respect of people's medicines administration. A best interests decision had been made to administer medicines covertly, that is in a way in which the person was unaware that they were taking it. This decision had been made in consultation with a psychiatrist, family members and staff from the home.

Staff told us of ways in which they gained consent to provide care to people. One member of staff told us, "I would ask them if they were ok. Then explain why I was there and ask if they were ok with me doing what I need to do?" Another member of staff gave us an example. They said, "I would greet them, ask them how they slept, ask them if they are ready to have personal care now or should I come back later." A third staff member said, "I always ask the resident, 'would you like to wash now?' If they refuse I would go back. If they still refuse I would record it in the daily log." Observations of staff during the lunch time period showed that they sought consent before they put on clothes protectors in the dining room.

People were not sure that all staff were trained to support them. One person told us, "Staff do keep changing and the new ones at night don't really know us well yet. So [I am] not sure about their training." Another person, when asked whether they thought staff were trained, commented, "Some are, yes some are." Staff also had mixed views about their training. One member of staff told us, "I worked here over a year ago and then left, I have been back three weeks and the only training I have had is five minutes, if that. No other induction training and I know my moving and handling is out of date. No-one has talked to me about a plan of my training or when it will begin properly. I am not happy with this." However another member of staff told us they had been well supported when they first started working at the service and had completed an induction. They told us they worked alongside an experienced staff member until they were assessed as competent to work unsupervised. They said, "I had a good induction." Another member of staff said, "I don't have a programme of training of what refreshers I need over the next 12 months or a record of what I have completed."

The registered manager showed us records that indicated that staff were 95% compliant with their training requirements. The provider had instigated a new clocking in system for staff and staff received messages from the electronic training system when training was due. Staff were unable to clock on until the message had been read. This ensured that staff were made aware of any training requirements. The registered manager told us that they guided staff during their induction period and monitored the practical implementation of the training staff had received. They also talked about training during staff supervision and arranged for additional training and development that staff had identified. They told us that two nurses had been enrolled to undertake management level three and the deputy manager had been enrolled for level five. The registered manager also told us of four training sessions for end of life care that had been arranged with a local hospice. Following the feedback we had provided on the first day of our inspection the registered manager had arranged for additional training to be provided to all staff on a weekly basis. Initially training on safeguarding and infection control had been prioritised.

The registered manager showed us records that indicated that staff had received supervision on a two monthly basis. Appraisals for staff had been carried out in September 2016. One member of staff told us, "Supervisions are every six weeks and recorded, my last appraisal was six months ago I think." Another member of staff said, "I had a supervision with the deputy manager last month; normally have them four to five times a year. Appraisal is with the manager. I can't remember when I had my last one."

People told us that they were supported to maintain their health and well-being. One person told us that the GP visited the home every Friday and they could ask to see them. Another person told us that they used the chiropodist who called at the home every four to six weeks and that an optician came to the service from time to time to test their eyesight. A hairdresser also called regularly at the home but some people had arranged for their own hairdresser to visit. Care records we looked at showed that other healthcare professionals, such as the mental health service, had been contacted when their advice or assistance to support someone was needed.

Inadequate

Is the service caring?

Our findings

People and relatives told us that staff did not always protect their dignity. One person said, "There is no comparison to the care I got at home before I came in here, for example I had a daily bed bath at home, I don't get that here." Another person said, "I have only had two showers and one bath in four weeks of being in here. I am used to a bed bath every day at home. The carers there did it routinely." A relative told us, "[Relative's] hair is often dirty. I don't know how often they are washing [them[, you know, giving [them] a good shower. My [sibling] has also commented on this." Another relative said, "They tell me that they change [relative] at 3.00pm but I know that this does not always happen. [Their] clothes are often stained with urine where [they have] been wet." A third relative said, "I wonder about this sometimes, you see [they] smell very bad when they bring [them] downstairs to the lounge. I am not sure they bath [them] enough." Another relative said, "[Relative] often does not smell as if [they have] been washed. [I'm] not sure when [they] had [their] last bath. I asked about this and they said they didn't have enough staff to give [them] one."

When walking around the building we observed people of both sexes sitting in their rooms with no covering on their bare legs. One person was seen to be wearing just a pyjama top. Another female resident was wearing a short nightdress with their underwear and incontinence pad clearly visible. Their door had been propped open and was opposite a room occupied by a male resident. Several male visitors were passing along the corridor. There appeared no recognition that people's privacy and dignity was compromised by this.

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

Staff told us of ways in which they promoted people's privacy. These included ensuring doors and curtains were closed when providing personal care and using towels to cover people as they were washed. One relative told us that laundry was always done and returned promptly and the bed linen was clean and comfortable.

We received mixed response when we asked whether the staff were caring. One person told us, "The care is alright here really. They are kind, patient and all okay." Another person said, "I get out of bed when they can come and get me out. It isn't very often but they are okay when they come to see me." A third person told us, "[The] carers are quite good really." However, a relative said, "Some of the carers here are very good, some don't seem to care at all. You can see that by the attitude they have to me."

There was a relaxed pleasant atmosphere between staff and service users. People were spoken to politely and there was supportive communication by staff when people were being assisted to move. One person told us, "Generally speaking they are speaking to me okay. They are kind and patient." Another person said, "They are polite enough when they come but they seem too busy to talk to you."

People were encouraged to be as independent as possible. One person told us, "I do get myself washed and

dressed but they are kind and ask me if I need any help." Another person said, "I get myself washed and dressed. I do everything for myself."

People felt that the established staff knew them and understood their needs. People who had not been living at the home for long were not sure how to make their preferences known to staff but thought maybe their relatives had done this for them. All the people we spoke with had a friend or a family member who was able to speak for them, although an advocacy service was available to people should they want to use it.

People told us that friends and family could come at any time and they were welcomed by the staff. Relatives reported that they were able to make themselves a cup of tea from the flasks. One relative said, "We used to be given a cup of tea when they gave the residents one in the afternoon but not now. We have to go and get our own. They are not allowed to give us one."

Inadequate

Is the service responsive?

Our findings

When we inspected the service in August 2015 we found that care plans did not contain sufficient information about the support people needed with specific medical conditions. During this inspection we found that this had been improved but care plans were not always followed by staff. We saw that assessments had been carried out before people entered the home to ensure that their needs could be met. Where people who had been admitted to the home for respite care they had specific care plans for their expected short stay developed. These were included in an 'Outcome Respite Care Booklet.' However, where a respite stay had been extended we saw that more detailed care plans had been developed based on the needs identified during the initial assessment. None of the people who lived at the home or their relatives could remember having been involved in the development or review of the care plans. Nobody knew when their care plan was next to be reviewed.

At the front of each person's care records was a quick reference guide that gave staff basic information about the person such as any allergies that had been identified, dietary requirements and instructions for moving. There were care plans that covered all areas of a person's life. These included areas such as nutrition, mobility, communication, medication and psychological and emotional needs. There were specific care plans which advised staff how to care for people with medical conditions or if they had special dietary requirements, such as having thickened drinks or soft food. One person was suffering from an infectious illness and was being 'barrier nursed' to prevent cross infection. We saw that there was a specific care plan in place for this.

When we inspected the service in August 2015 we found that some people felt that their needs were not always responded to appropriately. We found during this inspection that this was still the case. One person told us, "I have to wait so long to get up in the morning. I wanted to get up at 9.30 today. I first called at 10.00am, [I am] still here now (10.59am). They said when they came in they would only be two minutes. Where are they?" This person was eventually assisted to get up at 11.25am, having rung their call bell a further two times and almost two hours later than they had wished. Another person told us, "They are short staffed all the time so I have to wait." We saw that there was a care plan to address the psychological and emotional needs for one person which stated that their call bell must be in reach at all times. When we spoke with this person they told us, "Sometimes, when I think they have had enough of me or just want a bit of peace, they kick the call bell under the bed out of my reach. Then I have to start shouting. This happens at least once a day." This had caused them distress and also put them at serious risk of neglect. One person told us that they had been unable to continue with their private physiotherapy treatment as the staff would not arrange transport to their appointments. This had been arranged for rehabilitation purposes following the person suffering a stroke. They were very concerned that their recovery from the stroke would have been impaired as they had not been able to attend their appointments for the six week that they had been living at the home. We discussed this with the registered manager who, on the day of our inspection, made arrangements for a taxi to take the person to their future physiotherapy appointments.

A relative was very complimentary about the activity coordinator and the things they organised for residents. These included a gardening club, Bingo, arts and crafts, entertainers once a month, church

services once a month, balloon tennis and snakes and ladders on the floor. They said, "[Name] is brilliant." Another relative was very involved with the activities and made woodwork models which people had painted in the craft sessions. However, not everybody was happy with the choices available to them. One person told us, "They bring me in here every day. I don't choose to be in this lounge. I don't mind the Bingo but not every day." We also found that people who were cared for in bed had very little to stimulate them other than television or radio. There was no one to one activity undertaken with them. One person had both the radio and television on when we spoke with them. They told us this was their choice. One relative told us that the need to access lifts and mini lifts to get down steps with a wheelchair did not encourage them to take their relative to the communal areas to socialise or enable them to join in organised activities.

The failure to involve people in developing their care plans' the failure to follow care plans; the failure to provide for people's needs at the time they wanted and needed assistance; and the failure to ensure that people were protected from social isolation and enabled to engage in activities of their choice, were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the provider had an up to date complaints policy and complaints were recorded and monitored on an electronic system. We looked at two complaints that had been received in September 2016. We saw that one had been acknowledged on the day that it had been received. The registered manager had completed an investigation of the issues raised and a response had been sent to the complainant with the outcome of the investigation within the relevant time period. The second complaint had been investigated and responded to within 11 days.

One person told us, "I complained to the manager because my catheter stand had gone missing and no member of staff seemed able or willing to sort it out for me. Miraculously it reappeared." However, not all people we spoke with believed that the complaints system was effective and no one had been given a copy of the policy. One relative told us, "I made a complaint about how often they change [relative]. [They] need changing more often you see. They don't seem to want to listen to you if you raise things with them." Another relative said, "I have made a complaint about the noise in my [relative]'s room. The first time was three weeks ago but nothing has happened and they have empty rooms so I have contacted social services to take [them] home. [They are] not happy here now." This showed that the provider had not acted on people's complaints to improve the service that they received.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in August 2015 we found that the registered manager had insight into the improvements required at the service but had not taken action to address some high risk issues. During this inspection we found that improvements had been made in some areas, such as the development of care plans for specific medical conditions. However, action to address some serious problems, such as the cleanliness and bad odours within the home and the proper completion of care records, had been ineffective. We had noted that the newly introduced cleaning schedule was ineffective as there had been no follow up when weekly tasks had not been recorded as having been completed, even though the deputy manager had signed each day to show that they had made spot checks of every room. We also found that where areas were supposed to have been checked, such as corridors, there was still dirt, dust and debris visibly present. The registered manager and the deputy manager were aware of areas that presented an infection control hazard, such as doors around the building, but these had not been identified during infection control audits and no action had been taken to address the risks.

People and their relatives told us that there were meetings held occasionally at which they could discuss improvements that they wanted. One person told us that a residents meeting had been scheduled for the week before our inspection but this had been cancelled. A relative said, "I don't go to them and you don't get any minutes. Nothing changes and it makes me cross so I don't go." Another relative told us, "We have had residents meetings but not for a long time. I have asked and asked for minutes of the meetings so that something happens as a result of the things we bring up but I can't get any minutes. We discuss things but it is never implemented." The registered manager told us that they produced the minutes following each meeting and these were given to the activities coordinator to distribute to people's rooms. The registered manager admitted that she had not checked that this had been done.

We looked at the minutes of a meeting held in September 2016. Although there had been some positive feedback about people's experiences at that meeting, we saw that some areas of concern raised, such as not being given their choice of food, or having to wait for too long before being taken to their room or to the toilet, had not been addressed. These issues had been brought to our attention, by people and their relatives, during the inspection. This showed that any action taken to address people's concerns had been ineffective.

During the course of our inspection we looked at the documentation within the care records, including that related to food and fluid intake, skin integrity safeguards, continence, communication with other healthcare professionals and daily activities. We noted that these records had not always been completed correctly. For example, we did not see any empty' cups suggesting that fluids information was not completed correctly. There was no evidence to suggest whether the amounts of fluid documented were the amounts drunk or the initial amount in the beaker. One person's daily records had no entry made since 11 September 2016.

The failure to identify areas requiring improvement during quality audits; the failure to take effective action to ensure that the premises were clean and free from bad odours; the failure to take effective action to address concerns raised by people who lived at the home and their relatives; the failure to have care records

that were complete and up to date; were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that the registered manager did not stop and talk to them as they walked around the building. One relative told us, "Two of the senior carers run this place not the manager. One in particular is difficult to talk to and not approachable." However, when we accompanied the registered manager on a walk around the home they spoke with a number of people and clearly knew them. Staff told us the registered manager was approachable and they felt supported by them.

We saw that the registered manager held staff meetings with their heads of department at which they discussed areas such as care plans, training, supervision and housekeeping. However, staff told us that there were no staff meetings for the whole of the staff team. Each of the two units held meetings for their own staff. However, staff we spoke with felt that the unit meetings caused conflict and a lack of consistency in practice within the service.

We saw that an electronic feedback system was in the reception area. This had been recently introduced and was available to people, relatives and other visitors to give general feedback or answer specific feedback on the theme of the month. When we visited the home the theme was 'Dining'. The registered manager told us that there were two further electronic tablets around the home that people could use to provide feedback. The feedback was summarised automatically by the system and the results were available to the registered manager and the provider's regional manager. The regional manager told us that the provider was able to identify any regional, divisional or corporate trends by analysing the feedback. However, people and relatives seemed to be unaware of this opportunity and the feedback station in the reception area was not signposted prominently so people may have been unaware of it.

We saw that the provider had an electronic governance system, TRaCA, in which all information in areas such as home governance, information governance, housekeeping, resident care and health and safety checks was recorded on a monthly basis. This information was subject to check by the regional manager once a month. We saw that a manager from the provider's head office had visited to validate information provided by the registered manager in August 2016 and had found that some of the information recorded had been incorrect. The regional manager told us that where areas requiring improvement were identified the TRaCA system generated an action plan that was monitored by the regional manager until the registered manager signed it off as completed. The regional manager told us that information about the performance of individual services was fed up through the organisation to the Managing Director and the Chief Executive Officer.

Staff were not able to tell us of the visions or values of the service. One member of staff, "Making sure resident's needs are met. That they are happy and okay." Another member of staff told us they were to, "Make a happy home. [For the] residents to be happy and [it] feels safe and secure service." A third member of staff said, "Trying to give our best with the service we are giving here. We know we are struggling but we are trying our best."

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 People and their relatives had not been involved in the development of their care plans. Care plans were not always followed by staff. People did not receive care or assistance at the time they wanted or needed it. People were at risk of social isolation as many were cared for in their rooms and unable to participate in organised activities. The difficulties in accessing the communal areas from some rooms also meant that people living in those rooms were deterred from participating in any social activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was compromised by insufficient bathing and being left exposed to view whilst only in their underwear.

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 always given as prescribed. Management plans for risk assessments were not always followed.

People could not always summon staff when they needed assistance as they did not have call bells or the call bells were out of their reach

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not always able to access sufficient drinks. People were not always given the food that they had chosen. People were not always supported to eat their food appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment were not cleaned sufficiently to maintain a hygienic environment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always responded to in a way that satisfied the person who made the complaint.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality audits had failed to identify or address all areas that required improvement and were not always completed accurately. The registered manager had failed to take effective action to address improvements that had been identified as required in the service.

The documentation in people's care records was not always accurate or up to date.

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 insufficient staff to provide for people's needs at all times and to keep the premises clean and free from bad odours